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Examination of the stigma experiences and needs of individuals with serious mental illness

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Introduction

This project explores the stigma experienced by individuals with serious mental illness (SMI) and identifies their needs, both met and unmet. This is a somewhat unique approach as the data has been gathered solely from the perspective of individuals with mental illness. Researchers have stated that "the voice of service users is not strongly represented in the literature on stigma " (Thornicroft, 2007, p.153) and further that need has historically been "invariably oriented towards the perceptions of staff rather than those of patients" (Slade, Phelan, Thornicroft, & Parkman, 1996, p. 109). Corrigan and Penn point out that people with mental illness have unique insight into their disease and "excluding their perspective would omit a large and essential body of information" (Corrigan & Penn, 1997, p. 359). Thus, this project provides an important discussion of stigma and needs experienced by people with SMI.

Literature Review

Stigma

In a recent review of research related to the stigma of mental illness, 22% of studies found explored the views of individuals with a mental illness whereas nearly half (46.8%) assessed stigma from the perspective of the general public (Link, Yang, Phelan, & Collins, 2004). Consistent findings in this body of literature reveal that individuals with mental illness are perceived as dangerous and are viewed by others with fear, mistrust and discrimination (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Angermeyer & Matschinger, 2003a; Angermeyer & Matschinger, 2003b; Day, Edgren, & Eshleman, 2007; Phelan & Basow, 2007). While these results are important, it is essential that stigma be examined from the perspective of the men and women who are directly affected.

The stigma associated with mental illness is seen as one of the major barriers to diagnosis, treatment and community integration. Health Canada outlines that stigma and discrimination result in:

> stereotyping, fear, embarrassment, anger and avoidance behaviours. They force people to remain quiet about their mental illnesses, often causing them to delay seeking health care, avoid following through with recommended treatment and avoid sharing their concerns with family, friends, co-workers, employers, health service providers and others in the community (Health Canada, 2002, p. 21).

Link and Phelan summarize that "[s]tigma processes have a dramatic and probably under-recognized effect on the distribution of life chances such as employment opportunities, housing and access to medical care" (Link & Phelan, 2006, p.528). Thus, the potential impact of stigma on the lives of Canadians is widespread given that the life-time prevalence of mental illness in Canada is approximately 20% (Health Canada, 2002).

Background

Stigma in the modern period is in part tied to the development of psychiatric institutions in the late eighteenth and early nineteenth centuries (Fabrega, 1991). People with mental illness were typically housed in large institutions generally located on the outskirts of a given community. Hinshaw challenges that this resulted in severed relationships between those with a mental illness and those without (Hinshaw, 2007). In Fabrega's (1991) review of literature on the history of psychiatric stigma he argues that the methods of treatment developed during this period resulted in further isolation and alienation of the mentally ill. Those who were seen as "mad" were deemed reprehensible and regarded as "a lower subhuman form" (Fabrega, 1991, p. 108).

In his seminal work on stigma, Goffman outlines that a personal attribute, such as mental illness, is a mark which distinguishes the affected individual from the "normals" in a given

community (Goffman, 1963). When so marked, the individual is seen as a tainted person and, due to the negative attributes attached to the characteristic (or flaw), the stigma becomes "deeply discrediting" (Goffman, 1963, p. 3). Link and Phelan have built on Goffman's work and created a five-point model for conceptualizing how stigma occurs in society (Link et al., 2006; Link & Phelan, 2001). The first component is that members of society identify and then label human differences. While some of these differences have little to no relevance in daily life (such as eye colour), other characteristics are labeled with more negative connotations. The salience of these characteristics can vary over time and place. Second, an individual who is so labeled is then associated with these "undesirable characteristics" and is stereotyped. With regards to mental illness examples could include bizarre behaviours such as talking to one's self. Third, these individuals come to be seen as the "other" in opposition to those who do not possess the undesirable feature. Fourth, those who have been labeled "experience discrimination and loss of status" (Link et al., 2001, p. 370). This creates social hierarchies with labeled individuals at the bottom. Finally, Link and Phelan (Link et al., 2006) outline that there is a power differential between those who are stigmatized (and have no social, cultural, economic or political agency) and those who are not. As a result stigma can have a considerable impact on all aspects of a person's life, including employment, housing, community involvement, relationships, self-esteem, life satisfaction, rehabilitation and treatment and ultimately help-seeking behaviours.

Impact

Employment opportunities and workplaces are affected by the stigma associated with mental illness. Research indicates that individuals with mental illness are more likely to be unemployed due to stigma (Link, 1987). Wahl (1999a) and Dickerson and colleagues (2002) both surveyed individuals with SMI and reported that about half of respondents indicated they had been turned down for a position based on their mental illness. A recent review of the literature concluded that stigma was one of the barriers to individuals obtaining employment (Marwaha & Johnson, 2004). Unemployment is frequently combined with the devastating impact of poverty which can further compromise stigmatized individuals. For instance, Wilton interviewed people with mental illness who were unemployed or underemployed and found considerable financial hardship surviving on social assistance (Wilton, 2003). He concluded that "the stigmatizing effects of poverty intersect with, and exacerbate, the stigma of mental illness" (Wilton, 2003, p. 152).

For individuals with mental illness who are employed, stigma also impacts the work environment. A qualitative study focused on a supported work program indicated that stigma was one of the most imposing barriers that was faced by participants who had returned to paid employment (Boyce et al., 2008). In one focus group study with individuals with mental illness, participants indicated that they hesitated disclosing to their employers their psychiatric history because of stigma which was thought would lead to difficulties in the workplace (Dalgin & Gilbride, 2003). This is further supported in a study in Finland where the authors concluded that, in part, the high unemployment experienced by individuals with schizophrenia can be traced to negative attitudes on the part of employers (Honkonen, Stengard, Virtanen, & Salokangas, 2007).

Stigma also has an impact on where individuals with mental illness live. A number of studies have identified considerable problems with obtaining or keeping suitable housing. In one study, a researcher posed as a mental health worker attempting to access housing for a client (Alisky & Iczkowski, 1990). Forty-one percent of landlords rejected these individuals and of this number 22% either refused to rent to someone with a mental illness or denied that an apartment was available. In a consumer-led analysis of mental health services in one community, focus group participants identified they were treated inappropriately by housing authorities and one participant stated "[e]ven slum lords won't take you because they don't want psychiatrically ill people in their building" (People Advocating for Change through Empowerment (P.A.C.E.), 1993, p. 11). Researchers in another community interviewed individuals with mental illness and concluded that stigma limited access to safe and appropriate housing (Forchuk, Nelson, & Hall, 2006).

Even through an individual may acquire housing, studies have shown that people who have experienced stigma feel excluded from full participation in their communities and lack a sense of belonging. In a study with clients of assertive community treatment teams researchers found that respondents expected to experience devaluation and discrimination from people in their communities (Prince & Prince, 2002). Further work indicates that such feelings are not without justification. Boydell and colleagues interviewed people with mental illness who identified that they frequently tolerated "noxious" elements in their communities while at the same time attempting to "blend in" as to avoid discrimination (Boydell, Gladstone, Crawford, & Trainor, 1999). Kelly and McKenna reviewed the experiences of 100 deinstitutionalized clients (Kelly & McKenna, 1997). Over half of these individuals identified that they had experienced harassment or victimization in their communities as a result of their having a mental illness. This

involved "harassment while at home" (name calling, vandalized property), "harassment on the street" (name calling, verbal abuse, physical abuse), and financial exploitation carried out by children, teenagers and adults in their neighbourhoods. Respondents further indicated that they felt there was little they could do to combat these events.

This victimization is a cause for concern. Research indicates that individuals with mental illness are at increased risk of experiencing aggressive behaviour in their communities. For example, the one-year prevalence rate of violent victimization of people with psychosis has been calculated at more than double that of the general population (Walsh et al., 2003). Elevated differences between those with mental illness and the public have also been obtained elsewhere (Hodgins, Alderton, Cree, Aboud, & Mak, 2007). Furthermore, such violence may be particularly relevant for women. Rice (2006) interviewed women who identified that they felt stigmatized due to not only their mental illness but also because of the violence that they had experienced in their lives. Research also indicates that individuals with mental illness can face difficulties when interacting with police. Through the use of vignettes, researchers have found that police officers are less likely to investigate a crime when the victim is identified as having a mental illness (Watson, Corrigan, & Ottati, 2004a; Watson, Corrigan, & Ottati, 2004b). There is evidence that individuals with mental illness often do not report such events to the police and of those who do, many experienced negative responses ranging from rudeness to disbelief (Marley & Buila, 1999).

Stigma also has considerable impact on relationships and self-perception. Individuals who have been labeled with a mental illness have indicated changes in how they view their position in society (Link, 1987); this affects relationships with family, friends and partners. Stigmatized individuals express lower life satisfaction and have poorer social outcomes

(Markowitz, 1998; Markowitz, 2001; Holley, 1998). They are also more likely to suffer from lower self-esteem which can lead to reduced quality of life (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Markowitz, 1998; Markowitz, 2001; Rogers, Chamberlin, Ellison, & Crean, 1997; Rosenfield, 1997; Wahl, 1999a; Lai, Hong, & Chee, 2001). Further feelings associated with stigmatization are shame, discouragement, hurt, anger, alienation and reports of being shunned or avoided (Wahl, 1999a; Vellenga & Christenson, 1994; Link, Cullen, Mirotznik, & Struening, 1992; Wright, Gronfein, & Owens, 2000; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002). People feel demoralized and experience psychological distress (Link, 1987). Those who indicate higher levels of stigma have a lower sense of self-efficacy which in turn negatively affects personal empowerment (Vauth, Kleim, Wirtz, & Corrigan, 2007). Further work indicates that there is an association between high levels of stigma and increased positive symptoms and emotional discomfort (Lysaker, Davis, Warman, Strasburger, & Beattie, 2007).

Stigma can be internalized and in first-person accounts consumers have acknowledged the pervasive influence of "self-stigmatization" (Gallo, 1994; Ilana, 2002; Kiefer, 2001; Holmes & River, 1998). In this process, individuals "torture themselves to an extent that exceeds what they suffer from the very worst that society-at-large can dish out to them " (p. 407) (Gallo, 1994, p. 407). The endorsement of the negative stereotypes of mental illness can result in diminished self-esteem (Corrigan, Watson, & Barr, 2006; Lysaker, Roe, & Yanos, 2007) and further research indicates that the degree to which individuals endorse or legitimate stigma has an impact on how successfully one deals with it (Rusch, Lieb, Bohus, & Corrigan, 2006).

Unfortunately, stigma has been shown to pervade the lives of those with a mental illness regardless of their rehabilitation progress. In one study, participants were interviewed at program

intake and a year later. Although symptoms and functioning had improved, the stigmatizing effects of mental illness continued to negatively impact their lives (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Research has demonstrated that clients who are concerned about stigma at program intake show significantly more impairment with regards to social and leisure functioning upon follow up (Perlick et al., 2001). Similar results were obtained in a study that tracked deinstitutionalized clients who felt the damaging effects of stigma at the end of a two-year period (Wright et al., 2000). Further stigma has been found to cause problems with medication and program compliance. Sirey and colleagues (2001a) reported in a study of people with major depression that medication adherence was negatively impacted by perceived stigma. In further analysis they reported that stigma also affects continuation with treatment; this was particularly true for elderly participants (Sirey et al., 2001b).

Individuals who do not access treatment due to stigma also need to be taken into account. Studies in Edmonton and Ontario have found that about three quarters of those with a psychiatric diagnosis do not seek help (Bland, Newman, & Orn, 1997; Lin, Goering, Offord, Campbell, & Boyle, 1996). Hinshaw and Cicchetti (2000) argue that one of the reasons that people may not get the help that they need is stigma. For example, in a recent study conducted in northwestern Ontario with 80 individuals with SMI, 44% of respondents had delayed seeking treatment due to concerns about what others might think (Bédard, Gibbons, Mack, & Jones, 2003). The same has proved true in other work regardless of geographic location. Researchers in India and Pakistan examined barriers to mental health care access and identified that the "embarrassment" or stigma associated with mental illness was one of the key impediments (James et al., 2002). Stigma has also been identified as one of the major barriers to accessing mental health services in a population of homeless adults with SMI in the United States (Kim et al., 2007). Further,

researchers in England found that individuals with mental illness even hesitated to access information about their illnesses because of stigma (Powell & Clarke, 2006).

Need

Background

In *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* the Ministry of Health and Long-Term Care in Ontario states "the contractual, mutually respectful partnership between the client and the service provider is key to success" (Ontario Ministry of Health and Long-Term Care, 1999, p. 4). According to best practices outlined in this document, client input is essential to the development of an effective and responsive care plan. This negotiated approach incorporates mental health supports and services identified by clients and mental health workers. However, as Slade and colleagues point out, most instruments that have been developed to identify needs focus solely on the perspective of clinicians (Slade et al., 1996). Further, it has been identified in the literature that there is typically a low level of agreement between staff and clients on the presence or absence of need (Gibbons, Bédard, & Mack, 2005; Slade et al., 1996; Carter & Crosby, 1996; Massey & Wu, 1994; Rosenheck & Lam, 1997; Issakidis & Teesson, 1999; Lasalvia, Ruggeri, Mazzi, & Dall'Agnola, 2000; Calsaferri & Jongbloed, 1999). This is in part due to the fact that need is socially negotiated and influenced by a variety of factors including past experiences, expectations, education and personal values (Slade, 1994).

In the context of providing services to people with mental illness, it has been pointed out that the concept of need should be broadly defined as the ability to benefit from both health care and social care (Phelan et al., 1995). A tool frequently used to measure needs in such areas is the Camberwell Assessment of Need (CAN; Phelan et al., 1995). Referred to as "the de facto

standard for needs assessment of people with severe mental illness" (Wennstrom & Wiesel, 2006, p. 728), the CAN is unique in that it examines need from the perspective of health professionals as well as individuals with mental illness.

Impact

As identified by the CAN, areas of high needs found for people with SMI include: psychotic symptoms, daytime activities, company, physical health and the provision of information related to condition and treatment (Bengtsson-Tops & Hansson, 1999; Wennstrom et al., 2006). Unmet needs, or a need for which there is a partly effective or no care response, are an area of great concern. Wiersma points out in a review of CAN research that there is generally a ratio of 2-1 of met to unmet needs (Wiersma, 2006). Areas of high unmet need have been found to include: information, company, intimate relationships, physical health, daytime activity and psychological distress (Bengtsson-Tops et al., 1999). Meaningful social activities or daytime interactions have appeared as a high unmet need in other studies (Jansson, Sonnander, & Wiesel, 2003). Similar results were obtained a European study where daytime activities, company, psychotic symptoms, psychological distress, information and intimate relationships were the largest sources of unmet need (Thornicroft et al., 2004).

Further work has been done to determine factors which influence need or those characteristics which may predict the needs experienced by an individual. A recent study in Sweden interviewed a sample of the general population; those who had unmet mental health needs were more likely to be unemployed, poorly educated, single, of low socio economic status and with limited social supports (Forsell, 2006). Researchers in Montreal exploring a community sample found that unmet needs for services were associated with several factors including being diagnosed with a mental illness, not having ever had a marital relationship, being

unemployed and experiencing abuse in childhood (Lefebvre, Cyr, Lesage, Fournier, & Toupin, 2000). Ruggeri and colleagues found higher needs were impacted by the following variables: gender, employment status, symtomology and disability, functioning and quality of life, and frequency of contact with mental health services (Ruggeri et al., 2004).

Researchers have further found that contact with health services does not mean that an individual will have all of their needs met. For example, in a sample of 253 users of community mental health programs, researchers found that unmet needs did not differ based on client contact with mental health services (Barr, 2000). Lefebvre and colleagues concluded in their study that "service utilization . . . does not equate to met needs" (Lefebvre et al., 2000). Interestingly, intensity of care does not appear to be associated with an increased number of met needs. Research has demonstrated that clients who receive high levels of service are no more likely to indicate that their needs have been met than those who receive less intense care (Roth & Crane-Ross, 2002). Some may not even access services when in need. In a recent Swedish study researchers found that those who declined to seek services were more likely to feel a sense of "shame" which prevented them from accessing mental health care (Forsell, 2006).

Current Project

With the recognition that stigma and needs can have an impact on the lives of individuals with SMI, this project explores the results of study conducted at a local mental health program. A working group, comprising researchers, clinical staff and program clients, was formed to review program services provided by a large outpatient mental health program. The program offers comprehensive assessment and treatment to over 600 clients with SMI. The working group wanted to gain a better understanding of the stigma experiences and needs of clients in the

program.[a] As an additional element of the project, a convenience sample of people with mental illness who did not access the services provided by the program were also interviewed.

Method

Questionnaire Development

The questionnaire began with a demographics section. Questions were modified from the Northwestern Ontario Community Comprehensive Assessment Project client survey (Bédard et al., 2003). Respondents were asked about their: age, gender, employment, education, volunteer status, living conditions, source of income and cultural/racial group. There were also two questions about delays accessing mental health services due to stigma.

The questionnaire to examine stigma was developed by the researchers. Numerous sources were consulted to create the questions including: 1) input from the clients and staff in the working group, 2) the relevant literature, 3) stigma surveys available at the time (Link et al., 1997; Wahl, 1999a; Ritsher, Otilingam, & Grajales, 2003; Roman-Smith, 2000), 4) several reports produced by a local consumer/survivor agency (People Advocating for Change through Empowerment (P.A.C.E.), 1993; People Advocating for Change through Empowerment (P.A.C.E.), 1996; People Advocating for Change through Empowerment (P.A.C.E.), 2002), and 5) the reports from the working groups of a task force created by the provincial government to provide direction on mental health reform in Ontario (at the time the final report from this group had not been released to the public; Northwest Mental Health Implementation Task Force, 2002).

Fourteen different domains of stigma were identified (see Table 1) and were grouped into two broad constructs: 1) community; and 2) personal. Community experiences or influences encompass areas of stigma that individuals may experience in their contacts with and treatment

[a] The components of the project that will be discussed in this thesis project are the stigma associated with mental illness and participant needs. The client questionnaire also comprised a survey of client satisfaction with the services provided by the program. Staff of the program also completed a needs assessment of their clients. As these components did not form any part of the analyses for this project, the results are not discussed here.

by the general public and media as well as various social, educational, legal and government services. Personal experiences focus more directly on relationships and feelings about one's self. After developing the list of relevant stigma issues these data were presented to a group of individuals who used or had used mental health services and mental health professionals. Through a consensus process the group agreed on important stigma issues.

From this data collection process questions were created and were again viewed by services users and mental health professionals. As the constructs identified matched questions on the CESQ (Wahl, 1999a), modified versions of these questions were included in our survey. An example is, "I have worried that others will view me unfavorably because I am a consumer." For our survey this was changed to "I have felt that others will view me unfavourably because I have or had a mental illness." A 24-item questionnaire was created with possible responses ranging from 1 (never) to 5 (very often). Participants were asked to consider experiences that had occurred within the past year.

To explore the area of client needs, the Camberwell Assessment of Needs (CAN) was selected. The CAN is a 22-item questionnaire that was designed to explore both needs and unmet needs experienced by individuals with serious mental illness (Phelan et al., 1995). A need can be defined most simply as "the ability to benefit from care" (Wing, Brewin, & Thornicroft, 2001, p. 8). Alternatively, an unmet need is a need for which there is a partly effective or no care response. The CAN assesses need from a number areas including functional disability and social and emotional loneliness (Wennstrom, Sorbom, & Wiesel, 2004). Examples of CAN variables include: accommodation, food, psychotic symptoms, intimate relationships and money. The CAN has been found to be both reliable and valid (Phelan et al., 1995). To the list of CAN items, the working group added an additional seven questions that were thought to more fully explore

the situation of clients. They were: leisure time, smoking cessation, employment, crisis services, family doctor, planning for the future and self-help/peer support. The psychometric properties of the additional questions are unknown.

Training

Three consumer interviewers were hired to complete the interviews with the clients. These individuals were selected by the researchers with consultation from the working group. Consumer interviewers were used to ensure that respondents would be as comfortable as possible to share their feelings and experiences. Training was provided by the researchers. Interviewers took part in a two-day training session where they learned about the project and how to complete each of the questionnaires. They also received training on obtaining informed consent. The consumer interviewer training outline is provided in Appendix B.

Sample Selection

The total outpatient program client population at the time of assessment was 757. Stratified sampling (based on age, gender and length of time with the program) was used to obtain a representative sample of outpatient program clients (n=186). When a selected client did not participate in the survey, he/she was replaced by an individual matched for these characteristics. A convenience sample of individuals who did not access formal mental health services was also assessed. The target was to interview 50 people. To complete this part of the project, three agencies were involved, including: a supported housing program, a consumer/survivor organization and an emergency shelter. A chart detailing the recruitment process, including the number of participants at each stage, is available in Appendix C.

Data Collection Procedure

After a representative sample was generated from the original pool of all of the outpatient program clients, program staff was provided with the list of selected clients. The person who was most familiar with a client was responsible for contacting the individual. Staff was instructed to attempt to contact a client at least three times. When a client was contacted, the staff person provided basic information about the project and asked if the client was willing to be contacted by a consumer interviewer to receive more information. If the response was positive, contact details (name, telephone number, address, etc.) were recorded and passed to the researchers. The researchers then provided this information to a consumer interviewer.

A consumer interviewer contacted the client, provided more details about the project and invited the client to participate. If the response was positive, the interview was completed at the convenience of the participant. Informed consent was sought before the interview began. On average, the participant interviews took one hour to complete. They were conducted over the telephone or in-person at a place most comfortable for the participant. For example, interviews were completed in participants' homes, at coffee shops or at a local consumer/survivor organization. Participants were paid $10 for completing the interview and consumer interviewers received $15 for each interview. Transportation costs (bus pass, mileage costs etc.) for both the participants and interviewers were also covered by the project when necessary.

The sample of non-users came from three sources and different methods were used to access these individuals. The researchers met with staff from the supported housing program to explain the details of the project. It was determined that the best way to encourage client participation was by staff informing individuals who they believed might be interested. Staff faxed contact details for those who indicated interest to the researchers and then this information was relayed to a consumer interviewer who contacted the clients directly.

A multi-facetted approach was decided upon to generate interest at the consumer/survivor organization. Two articles were written for inclusion in the newsletter provided to the membership, posters were displayed in the building and staff was encouraged to mention the project to anyone who they thought might be interested. Interested individuals were told to contact the researchers directly where they learned more about the project. If still interested, the participant supplied contact information which was passed on to a consumer interviewer. Several individuals did not have regular access to a telephone and thus were given with the phone number of the consumer interviewer who they contacted directly. The researchers sought interviewer consent for this process before proceeding.

To access individuals at the emergency shelter, a staff member at the shelter met with the consumer interviewer and introduced her to individuals who she thought would be willing to take part in the project. The interviewer introduced herself to the individual and explained the study in detail. If the response was positive, the interviewer obtained informed consent and then conducted the interview.

Ethics Review

Before proceeding, this project received ethics approval in 2003 from the Lakehead Psychiatric Hospital Ethics Committee.

Statistical Analysis

Demographic information and the stigma questionnaire results were presented using descriptive statistics (means and frequencies). All questions on the stigma questionnaire were scored so that higher values indicate greater stigma; questions 8, 9, 13, 15, 16 and 24 were reverse coded. Thus, for all questions a response in the lower numbers (1 or 2) indicates a better score or a domain where people have experienced stigma less often. A "3" indicates the middle

value or "sometimes". Higher numbers indicate greater reported stigma. For the total scores on the stigma questionnaire, prorated scores were calculated for participants who answered at least 70% of the items. Independent samples t-tests were used to compare those who indicated that they had delayed seeking mental health services and who indicated that they did not. Similar analyses were used to examine the experiences of men and women. Chi square was used to examine differences in need between these groups. Significance was set at $p<.05$. All analyses were conducting using the Statistical Package for the Social Sciences (SPSS) for Windows, Version 15.0.

Results

Demographics

In total 186 clients were selected for assessment and 89 interviews were completed for a response rate of 47.8%. Data from the entire client population (n=757) at the time of sampling and the actual sample (n=89) are provided in Table 2. The sample does not differ appreciably from the full population in terms of age, χ^2 (4, N = 757) = 5.94, p = 0.20, and gender, χ^2 (1, N = 757) = .004, p = 0.95. Length of time with the program did differ significantly between the sample and the client population, χ^2 (6, N = 757) = 13.10, p = .04. The sample of non-users (n=34) represents a convenience sample.

Demographic information was collected on all participants and is presented in Table 3. Overall, the majority of the sample was female (59.3%); this was true for each of the groups except for the shelter where 80 percent of the sample was male. The mean age of participants was in the mid 40s. Most people lived alone (45.5 %) or with a spouse (32.5%). With the exception of the emergency shelter (where all individuals lived at the shelter), the majority of participants lived in a house or apartment (88.6 %). The overwhelming majority of participants

had not moved in the past year, however all participants from the shelter indicated that they had move once or more. Most individuals were not working (74%), nearly half did volunteer work (46.3%) and most were not in school (85.4%). Education level varied among programs. For the large outpatient program, nearly 60% (or 52 individuals) had some or complete post-secondary education. This was similar for the supported housing program (77.7%). However for the consumer/survivor organization and the emergency shelter, the majority had completed high school or less (73.3% and 70% respectively). For most individuals, their main source of income was some form of pension – Ontario Disability Support Pension (37.4%) or CPP Disability Pension (15.4%). Four individuals from the shelter indicated that they had no income. For the outpatient program and the supported housing program most participants indicated that they came from a cultural/racial group that was white (86.5% and 77.8% respectively). However, for the consumer/survivor organization and the emergency, the majority of participants indicated an Aboriginal or Métis (66.7% and 80% respectively) cultural/racial background.

Respondents were asked the question "Have you ever delayed seeking mental health services because you were afraid of what people might think of you?" Sixty-five (53.3%) individuals indicated that they had done so and of those, ten (15.6%) indicated that this had been in the past six months. Respondents were also asked "Have you felt uncomfortable coming to Lakehead Psychiatric Hospital [the local psychiatric hospital] because you were afraid of what other people might think of you?" Just over half (51.3%) responded positively to this question. However, all participants from the supported housing program (n=9) indicated that they felt uncomfortable coming to the psychiatric hospital.

Stigma Questionnaire

Higher scores indicate areas where individuals have experienced more stigma. The full results can be found in Table 4.

Outpatient Program

For the large outpatient program, analysis indicates that areas of concern include: avoiding telling others about having a mental illness ($M = 3.51$, SD = 1.37), feeling bad about self because of having a mental illness ($M = 3.45$, $SD = 1.36$) and treatment by law enforcement officers ($M = 3.65$, $SD = 1.61$). Alternatively, few respondents indicated that they had been denied educational opportunities ($M = 1.18$, $SD = 0.74$), had trouble getting permits ($M = 1.19$, $SD = 0.73$) or problems with places where they get their money ($M = 1.25$, $SD = 0.81$). Importantly, the results also indicate that respondents felt that mental health professionals treated them with respect ($M = 1.56$, $SD = 0.74$).

Supported Housing Program

For participants from the supported housing program, sources of greatest stigma were treatment by law enforcement ($M = 4.25$, $SD = 1.5$), hearing unfavourable things from others ($M = 3.78$, $SD = 1.09$) and feeling bad about one's self ($M = 3.5$, $SD = 1.51$). Respondents indicated that they had never been denied educational opportunities ($M = 1$, $SD = 0$) or permits ($M = 1$, $SD = 0$) and had very few problems with places where they get their money ($M = 1.13$, $SD = 0.35$).

Consumer/Survivor Organization

Participants from the consumer/survivor organization indicated high scores with regards to hearing unfavourable things from others ($M = 3.53$, $SD = 0.83$), avoiding telling others ($M = 3.44$, $SD = 1.33$) and treatment by law enforcement ($M = 3.63$, $SD = 1.41$). Sources of the least

stigma were denial of educational opportunities ($M = 1.1$, $SD = 0.32$), being excluded from volunteer work ($M = 1.14$, $SD = 0.36$) and trouble getting permits ($M = 1.22$, $SD = 0.67$).

Emergency Shelter

Individuals from the emergency shelter indicated that they had experienced stigma with regards to treatment by law enforcement ($M = 4$, $SD = 1$), hearing unfavourable things from others ($M = 3.8$, $SD = 0.8$) and feeling bad about one's self ($M = 3.3$, $SD = 0.68$). Participants indicated that they had never experienced being excluded from volunteer work or social activities, denied educational opportunities or any kind of permit as a result of having a mental illness (for each question, $M = 1$, $SD = 0$).

Camberwell Assessment of Need

The design of the Camberwell Assessment of Need (CAN) provides opportunity for the analysis of needs – both met and unmet. Overall, participants identified an average of six needs ($M = 6.42$, $SD = 4.23$) and two unmet needs ($M = 1.96$, $SD = 2.46$). Participants from the outpatient program identified an average of six needs ($M = 6.18$, $SD = 4.29$) and nearly two unmet needs ($M = 1.98$, $SD = 2.52$). Participants from the supported housing program indicated nearly seven needs ($M = 6.79$, $SD = 5.15$) and just over one unmet need ($M = 1.37$, $SD = 1.95$). Participants from the consumer/survivor organization identified an average of close to eight needs ($M = 7.64$, $SD = 4.22$) and just over two unmet needs ($M = 2.21$, $SD = 2.44$). Participants from the emergency shelter identified just over six needs on average ($M = 6.31$, $SD = 3.73$) and nearly two unmet needs ($M = 1.90$, $SD = 2.56$). Full results on all CAN questions can be found in Table 5.

Outpatient Program

The three most frequently identified areas of need by outpatient program clients include: psychological distress (49.4% Met; 21.3% Unmet; 70.7% Total), company (29.5% Met; 20.5% Unmet; 50.0% Total) and planning for the future (30.6% Met; 5.9% Unmet; 36.5% Total). Psychological distress and company also comprised a domain of high unmet need. The next highest unmet need was sexual expression which was indicated by 17 respondents (20% Unmet).

In the area of psychological distress, outpatient program clients indicated that they were receiving low levels of support from friends and family ($M = 1.42$, $SD = 0.88$) as well as from local services ($M = 1.41$, $SD = 0.74$). Clients of outpatient program indicated they felt significantly more support was needed from local services ($M = 1.73$, $SD = 0.63$), $t(58) = -3.94$, $p < .001$, than was currently received. The majority of clients reported they were receiving the right type of help necessary (79.4%) and were satisfied with the amount help received (66.7%).

With regards to company or "social contact," outpatient program clients indicated that they were receiving low support from family/relatives ($M = 1.11$, $SD = 0.92$) and an even lower level of support from local services ($M = 0.55$, $SD = 0.82$). Clients reported they need significantly more support from local services in this area ($M = 1.46$, $SD = 0.91$), $t(38) = -6.58$, $p < .001$. Less than half of these clients indicated they were getting the right type of help (47.7%) and only 13 (29.5%) were satisfied with the amount of help provided.

Outpatient program clients indicated that they were receiving low support in the area of planning for the future as well (friends/relatives, $M = 0.77$, $SD = 0.8$; local services, $M = 0.74$, $SD = 0.77$) and less than half were satisfied with this amount (41.9%). Fourteen individuals (45.2%) thought that they were getting the appropriate type of help, however overall they felt that they need closer to a moderate level of support ($M = 1.67$, $SD = 0.8$). The difference

between support required and that currently received was statistically significant, $t(29) = -5.34$, $p < .001$.

Sexual expression was indicated as a need by 29 individuals, 17 of whom identified it as an unmet need. The results further demonstrate that clients are receiving almost no support from friends/relatives ($M = 0.17$, $SD = 0.38$) and local services ($M = 0.31$, $SD = 0.6$). Respondents indicated that they could benefit from a significant increase in local service support ($M = 1.74$, $SD = 1.05$), $t(22) = -5.43$, $p < .001$. Only one in five individuals (20.7%) indicated they received the right type of help in this domain and only 27.6% of respondents were satisfied with the amount of help received.

Supported Housing Program

The majority of the supported housing participants identified psychological distress as an area of need, including two individuals for whom this presented an unmet need (44.4% Met; 22.2% Unmet; 66.6% Total). Supported housing participants indicated they receive between low and moderate levels of support (friends/relatives, $M = 1.33$, $SD = 0.88$; local services, $M = 1.5$, $SD = 0.84$). The results also demonstrate that close to a moderate level of support is needed from local services ($M = 1.83$, $SD = 0.98$). Although they all ($n = 6$) indicated that they received the right type of help, only 66.7% were satisfied with the amount.

Money or "budgeting" and paying the bills was also an area of need, although none identified it as an unmet need (Met 66.7%; 0 Unmet; 66.7% Total). Overall, supported housing respondents indicated that they received a very low level of support from friends and relatives in this area ($M = 0.33$, $SD = 0.52$). There was a match between the level of support received and that which is required ($M = 1.5$, $SD = 0.55$). All ($n = 6$) thought that they were getting the right type of help in this area and satisfaction was high (83.3%).

Other areas of high need included food (Met 44.4%; 0 Unmet; 44.4% Total) and company (33.3% Met; 11.1% Unmet; 44.4% Total). Support received for getting enough to eat and food preparation ranged between low and moderate (friends/relatives, $M = 1.25$, $SD = 0.96$; local services, $M = 1.5$, $SD = 0.58$). Respondents indicated that they require a close to a moderate level of support ($M = 1.75$, $SD = 0.5$), such as providing meals on a weekly basis. While all ($n = 4$) felt that they were getting the right type of help, only half ($n = 2$) were satisfied with the amount of help that they were receiving. Regarding company, participants indicated that they receive a low level of support from friends and relatives in this area ($M = 0.75$, $SD = 0.96$) and closer to a moderate level from local services ($M = 1.75$, $SD = 0.5$). They felt that they require "moderate" help from service providers with their social lives ($M = 2$, $SD = 0$) and the majority felt that they were receiving the right type of help (75%). Three-quarters were satisfied with the amount of help that they received with social contacts.

Consumer/Survivor Organization

Participants from the consumer/survivor organization identified need in the area of food, with five individuals indicated that getting enough to eat and preparing food presents an unmet need (33.3% Met; 33.3% Unmet; 66.7% Total). Participants received very little help from friends and relatives with regards to food and meal provision ($M = 0.3$, $SD = 0.67$). Assistance from local services was a little higher ($M = 1$, $SD = 0.67$), however, respondents indicated that they actually require significantly more help ($M = 2$, $SD = 0.67$), $t(9) = -2.74$, $p = .02$. While 70% indicated that they are receiving the right type of help, only 30% were satisfied with the amount of help that they get.

Accommodation represented an area of need for nine individuals (46.7% Met; 13.3% Unmet; 60% Total). Help received from friends and relatives was low ($M = 1.11$, $SD = 1.36$) and

even lower from local services ($M = 0.63$, $SD = 1.19$). The score for help needed from local services indicates that respondents require a moderate to high level of help, which represents a significant difference ($M = 2.44$, $SD = 1.01$), $t(7) = -3.33$, $p = .01$. Examples of an appropriate level of response range from major housing improvements to being rehoused. Very few respondents were satisfied with the amount of help in this area (33.3%) although 66.7% indicated that they were receiving the right type of help.

Psychological distress represented a need for just over half of the participants from the consumer/survivor organization; only one individual indicated an unmet need in this area (46.7% Met; 6.7% Unmet; 53.4% Total). Overall, participants were receiving low support from friends and relatives ($M = 0.75$, $SD = 0.89$). They indicated that they get between low and moderate support from local services ($M = 1.5$, $SD = 0.93$) but actually require a significantly higher level ($M = 2$, $SD = 0.53$), $t(7) = -2.65$, $p = .03$. The majority indicated that they are receiving the right type of help with psychological distress (87.5%) but only half ($n = 4$) are satisfied with the amount of help that they receive.

High unmet need or domains which represent a serious problem for participants from the consumer/survivor organization were physical health (0 Met; 26.7% Unmet; 26.7% Total) and telephone (13.3% Met; 26.7% Unmet; 40% Total). Of the four individuals who needed assistance with their physical health, on average they receive low support from friends/relatives ($M = 1$, $SD = 1.15$) and local services ($M = 0.75$, $SD = 0.96$). They indicated that they need a moderate level of support from local services ($M = 2.25$, $SD = 0.5$), such as regular visits with a doctor or nurse. None felt that they were getting the right type of help in this area and none were satisfied with the amount of help. Accessing and using the telephone represented a serious problem or unmet need for 4 individuals (26.7%). On average they received low support from friends/relatives (*M*

= 1.17, *SD* = 0.98) and local services (*M* = 1, *SD* = 0.63). They indicated that they need a moderate level of support (*M* = 2.5, *SD* = 0.55). Most thought that the type of help was appropriate (83.3%) although only one was satisfied with the amount.

Emergency Shelter

Six participants from the emergency shelter indicated need in the area of accommodation which included an unmet need for one of these individuals (50% Met; 10% Unmet; 60% Total). They currently receive low support from friends and family (*M* = 1.17, *SD* = 1.33) and even less from local services (*M* = 0.83, *SD* = 1.33). Only half (*n* = 3) are satisfied with the amount of help that they receive. They further indicated that they require slightly more than moderate help (*M* = 2.17, *SD* = 1.17). The majority felt that they are getting the right type of help (83.3%).

Food was also an area of considerable need as well as unmet need (20% Met; 30% Unmet; 50% Total). Help from friends and relatives (*M* = 0.6, *SD* = 0.89) as well as local services (*M* = 1.2, *SD* = 0.45) was low. Respondents indicated that they require closer to moderate help from local services (*M* = 1.8, *SD* = 0.45). While all (*n* = 5) indicated that they were getting the right type of help, only two individuals were satisfied with the amount of help that they received.

Telephone was also an area of high need (20% Met; 20% Unmet; 40% Total). Respondents indicated that they have less than monthly access to a telephone through friends and relatives (*M* = 1.25, *SD* = 0.96) and local services (*M* = 0.75, *SD* = 0.5). They felt that they needed significantly higher support with accessing a telephone (*M* = 2.75, *SD* = 0.5), t(3) = -4.90, p = .02). All (n = 4) felt that they received the right type of help in this area but none (n = 4) were satisfied with the amount.

Although psychological distress was an area of need, it was not an unmet need for any participants from the emergency shelter (40% Met; 0 Unmet; 40% Total). Participants indicated that they get low help from friends and relatives with regards to psychological distress ($M = 1$, $SD = 0.82$) and slightly more from local services ($M = 1.5$, $SD = 0.58$). They indicated that they need a moderate level of support from providers ($M = 2$, $SD = 0$), such as weekly counseling sessions. All ($n = 4$) felt that they received the right type of help in this area but only half ($n = 2$) were satisfied with the amount.

An area of highest unmet need or a domain that represented a serious problem was alcohol (0 Met; 30% Unmet; 30% Total). Three individuals indicated that their current drinking pattern was harmful or uncontrollable. They received very low support from friends/relatives ($M = 0.67$, $SD = 1.15$) and local services ($M = 0.67$, $SD = 1.15$) to deal with this behaviour. A moderate level of support was needed from local services ($M = 1.67$, $SD = 1.53$). Two indicated that they received the right type of help with alcohol consumption and all were satisfied with the amount of help received.

Stigma, Needs and Accessing Services

Some additional analyses were conducted on the data to obtain a more comprehensive understanding of the stigma experiences and needs of individuals with serious mental illness. First, analyses were done to examine those who indicated that they had delayed seeking mental health services because they were "afraid of what other people might think." Next, the responses to the stigma questionnaire and the needs (met and unmet) identified on the CAN were examined by comparing those who felt uncomfortable coming to the local psychiatric hospital and those who did not. For all of these additional analyses respondents from all programs ($N = 123$;

outpatient program, supported housing program, consumer/survivor organization, and the emergency shelter) were grouped together.

Overall, those who responded positively to the question about delaying seeking mental health services due to concerns about what others may think scored ten points higher on the stigma questionnaire, (M = 60.3, SD = 13.74), as compared to those who did not delay (M = 50.98, SD = 13.54), $t(110) = -3.62$, $p = 01$. There were also significant differences on individual items. Those who had delayed seeking mental health services were more likely to report that they felt that they would be viewed unfavourably by others, $t(120) = -3.81$, $p < .001$, had heard unfavourable things from others, $t(120) = -2.68$, $p = .01$, and had seen or read unfavourable things in the media, $t(118) = -3.26$, $p = .01$. They were more likely to report that they had been shunned or avoided by others, $t(118) = -3.76$, $p = .01$ and they had also acted in the same manner toward others with mental illness, $t(120) = -2.03$, $p = .05$. They were more likely to have been told to lower expectations in life, $t(119) = -3.18$, $p = .002$, and to have felt bad about themselves, $t(118) = -3.74$, $p < .001$. Finally, they were more likely to have felt uncomfortable going to places providing mental health services, $t(118) = -3.51$, $p = .001$. See Table 6 for further details.

Those who had delayed seeking services (M = 7.23, SD = 4.31) had nearly two more CAN-identified needs as compared to those who had not, (M = 5.36, SD = 3.98), $t(119) = -2.46$, $p = .02$, (see Table 7). They were more likely to have indicated needs in the areas of: psychological distress, χ^2 (1, N = 122) = 5.93, $p = .02$, safety to self, χ^2 (1, N = 121) = 11.47, p = .01, safety to others, χ^2 (1, N = 121) = 4.49, $p = .03$, and planning for the future, χ^2 (1, N = 118) = 6.42, $p = .01$. Complete results can be found in Table 8. There was no difference between the number of unmet needs for the two groups (see Table 9). For unmet needs only a few variables reached statistical significance; those who delayed required more help with psychological

distress, χ^2 (1, N = 122) = 4.08, p = .04, safety to self, χ^2 (1, N = 121) = 4.7, p = .03, and intimate relationships, χ^2 (1, N = 119) = 4.46, p = .04. Alternatively, those who had not delayed accessing services had a greater unmet need for problems associated with alcohol consumption, χ^2 (1, N = 121) = 4.65, p = .03. Further details can be found in Table 10.

Discussion

This report describes the results of a study examining the needs and the stigma experienced by individuals with SMI. While the results indicate that participants experienced stigma in all of the domains covered in the questionnaire, there were areas of varying frequency. Lower frequencies were evident in areas such as being turned down for a job, excluded from volunteering, problems in legal proceedings, difficulties renting, denied educational opportunities, denied permits/licenses and problems accessing money. Respondents were asked to consider their experiences within the past year when answering the stigma questionnaire. Many respondents may have answered "never" on these questions because they did not experience such events in the past year. For example, someone may have applied for a job and not been turned down due to having a mental illness. However, some individuals may have responded "never" because they simply had not applied for a job. Due to the skewed responses, these data should be interpreted cautiously.

The questions where there is evidence of considerable stigma are the questions that deal with personal views and feelings. Research indicates that people with mental illness use a variety of strategies to cope with the negative impacts of stigma. Link and colleagues (2002) state that

> ... many people with mental illnesses may feel set apart, different, and perhaps even ashamed as a consequence of having developed a condition that is strongly devalued by society at large. In addition, people with mental illnesses are likely to adopt coping approaches designed to avoid or reduce the possibility of rejection (p. 204).

Examples of coping that have been explored in the literature include withdrawing from social contact, secrecy in disclosing psychiatric history, deception, normalization, political activism and attempting to educate others about mental illness (Link, Mirotznik, & Cullen, 1991; Vellenga et al., 1994; Crawford & Brown, 2002; Herman, 1993; Wahl, 1999b; Holmes et al., 1998). Some reject the negative labels and stereotypes associated with mental illness as not valid or applicable (Camp, Finlay, & Lyon, 2002). Other reports indicate that "institutional retreatism" becomes a way for individuals to escape from the pressure of living in a community that is perceived to reject them (Herman & Smith, 1989). However, what is also evident is that few strategies have been introduced to combat the stigma associated with mental illness and ultimately "[v]ery little is known about effective interventions to reduce stigma" (Thornicroft, 2007, p. 181).

Working with clients to provide them with the skills to cope with stigma and how they interpret such events may be areas where clinicians could have an important role to play. Dickerson and colleagues outline the importance of rehabilitation programming that places high priority on developing ways to cope effectively with stigma (Dickerson, Sommerville, & Origoni, 2002). Researcher have indicated that such "intrapersonal" interventions focused on empowerment may in fact be the best means of stigma-reduction (Heijnders & Van Der, 2006; Thornicroft, 2007; Prince et al., 2002; Bagley & King, 2005; Bjorkman, Svensson, & Lundberg, 2007). In further analysis of the stigma experience, Watson and colleagues (2007) were also able to draw conclusions about possible effective interventions, including self-help groups and cognitive behavioural therapy. However, these types of anti-stigma interventions must be relevant to the stigma issues experienced by people with mental illness and it is essential to measure their successes.

Link and colleagues (2002) explored the impact of a stigma intervention designed to assist individuals with mental illness overcome stigma using pre and post assessments. Although the intervention was ultimately unsuccessful in reducing stigma experienced by participants, the researchers conclude that the details collected through use of a stigma questionnaire indicate "possible points of intervention in perceptions, experiences, coping orientation, stigma feelings and their interconnections" (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 222). They point out that the stigma associated with mental illness is powerful and there is a need for "interventions that simultaneously address multiple levels of influence and that are targeted at the stigmatizers as well as the persons who are the recipients of stigma" (Link et al., 2002, p. 224).

The fight against stigma must also occur on a community and global level and this is where professionals in the field of public health have an important role to play. Herrman and colleagues (2004), in their report for the World Health Organization, argue that to make changes within the arena of mental health, public health officials must take the opportunity to engage in promotion campaigns that are targeted to the broader population. In fact the World Health Organization indicates that the widespread stigma associated with mental illness is one of the primary reasons why "a public health approach is the most appropriate method of response" (World Health Organization, 2001). Interventions directed at the general public have been popular and anti-stigma campaigns have taken place on a community and global level (Sartorius, 1997; Sartorius & Schulze, 2005; Pinfold, Thornicroft, Huxley, & Farmer, 2005). Studies have shown that the public may gain some benefit from anti-stigma projects (Jorm, Christensen, & Griffiths, 2005; Crisp, Gelder, Goddard, & Meltzer, 2005). At a community level educational workshops can also have a positive impact (Pinfold et al., 2003; Pinfold et al., 2005; Corrigan et

al., 2001). These types of smaller interventions have been targeted to specific populations, such as journalists, students, teachers, employers and the psychiatric community. Of particular effectiveness have been presentations provided by individuals with mental illness (Corrigan, Larson, Sells, Niessen, & Watson, 2007). Some more novel interventions have included drama groups composed of individuals with SMI, radio broadcasts and peer support programs (Estroff, Penn, & Toporek, 2004). One study conducted in New Zealand interviewed individuals with mental illness after a nation-wide, anti-stigma campaign and the results reported appear to indicate that the program is having some success (Vaughan & Hansen, 2004).

The other component of the survey was an extensive needs assessment which indicated met and unmet needs in all 29 domains examined. When a client's needs are unmet, there can be significant repercussions for that individual. For example, research has indicated that a higher number of unmet needs is associated with a lower quality of life(QoL; Slade et al., 2004; Slade, Leese, Taylor, & Thornicroft, 1999; Lasalvia et al., 2005). In turn, low QoL has been associated with a range of factors including anxiety, depression, psychotic symptoms, and limited social activities (Thornicroft et al., 2004). There is further evidence that greater unmet need is associated with decreased quality of life (Hansson, 2006).

For participants from the large outpatient program, high need was most evident in dealing with feelings of depression and anxiety, limitations in social activities as well as problems setting personal goals and planning for the future. These were also areas of high unmet need, which points out that clients could benefit from more clinical support in these areas. Psychological interventions are certainly areas where clinicians have expertise. Further support in areas such as social activities indicates that perhaps more work could be done by clinicians to recognize and support all aspects of an individual's well being. Participants further identified that many had

serious problems in their sex lives and requested a much higher level of support from service providers in this area. Researchers have indicated that this may be a more difficult area for clinicians to address as there is no easily defined services response (Slade et al., 1996).

For individuals from the supported housing program needs centered on services such as food, money and employment. Respondents also identified that they had need in the area of psychological distress and company. However, there was no statistically significant difference between support received and support required for any of these areas of need and generally satisfaction with the amount of support was high. Staff could consider advocacy work with government organizations to increase social assistance and benefits for individuals with SMI. This could potentially eliminate food and money as areas of need. It may also be beneficial to work with other organizations to encourage the social activities and vocational efforts of their clients.

Individuals from the consumer/survivor organization and the emergency shelter identified problems in similar areas of basic need such as food, accommodation, access to a telephone and physical health issues. This was combined with a high need in the area of psychological distress. Those from the shelter further indicated that alcohol consumption represented a serious problem. Provision of these types of services may fall outside of the scope of those offered by the staff at the consumer/survivor organization and the emergency shelter and indicate that these individuals may require more intensive supports from health care providers. Basic needs for housing, food and mental and physical health treatment need to be met with the assistance of other community programs. These programs may benefit, for example, from having a front-line health care professional, such as a nurse, on site to deal directly with clients' health care concerns.

Further analyses were conducted to more fully explore the data. Of concern was the high percentage of clients who had delayed seeking mental health services because they were concerned about what others might think as well as the similar results regarding individuals who had hesitated to access services provided by the local psychiatric hospital. These individuals experienced more stigma with regards to how others see them and how they see themselves. Perhaps most telling, they felt uncomfortable going places where mental health services are provided. This is of concern given that these individuals also indicated significantly more needs than those who had not delayed accessing services. They were more likely to have needs in areas with considerable implications such as a risk of self-harm/suicide or of violence toward others. Given the cross sectional nature of the present study, it is impossible to determine the direction of the relationship between stigma and needs – does not accessing services result in more needs and greater stigma *or* do more needs and greater stigma result in not accessing services? Hinshaw (2007) argues that when stigma is internalized by individuals, it is "debilitating, with the potential for the recipient of the message to close off any further communication" (p. 149). Thus, it is possible that those who experience stigma actually limit their contact with others which in turn makes them more vulnerable and results in more needs. This is an area for future research.

One of the limitations of the study is that the results may not be generalizable to all people with mental illness. While attempts were made to obtain a representative sample of one third of the users from the large outpatient program, the final response rate reflects a much smaller sample that is not fully representative. The users from the other programs represent a convenience sample. Furthermore, individuals from the consumer/survivor agency and the emergency shelter self-identified as having a serious mental illness. At the time of the project,

the outpatient program did not have a centralized record of client diagnoses. No formal diagnosis was made by the interviewers and no one was excluded for this reason. Thus, the psychiatric diagnosis of all participants is unknown.

Conclusion

The stigma associated with mental illness has enormous impact on the lives of individuals with serious mental illness. The results from this study demonstrate that people who indicate high levels of stigma may hesitate to access services due to concerns about what others may think of them. They also express more needs than those who do not delay accessing services. This represents a considerable public health concern given that not only is there a large number of Canadians who live with mental illness but also the fact that stigma is pervasive and has a widespread impact. It is essential that interventions continue at the individual and clinical level and that community and global anti-stigma presence be further enhanced.

Tables

Table 1: Sources of stigma

	Sources Consulted		
Stigma Domains	Literature	Existing Surveys	Reports
General Public	√	√	√
Mental Health and Crisis Services	√		√
Psychiatric Hospital		√	√
Media	√	√	√
Employment	√	√	√
Finances	√		√
Relationships	√	√	√
Self-Stigma	√		√
Secrecy	√	√	√
Social/Recreation		√	√
Legal Services		√	√
Government	√	√	
Housing	√	√	√
Education	√		√

Table 2: Comparison of total outpatient program clients to sample n (%)

	Total Outpatient Program Clients n=757	Sample of Outpatient Program Clients n=89	χ^2	p
Age				
< 25 Years	80 (10.6)	6 (6.7)	5.94	0.20
25 to 39 Years	265 (35.0)	31 (34.8)		
40 to 54 Years	295 (39.0)	34 (38.2)		
55+ Years	117 (15.5)	18 (20.2)		
Gender				
Male	283 (37.3)	33 (37.1)	.004	0.95
Female	474 (62.6)	56 (62.9)		
Length of time in the program				
< 6 months	231 (30.5)	15 (16.9)	13.10	.04
6-12 months	170 (22.5)	20 (22.5)		
12 to 18 months	84 (11.1)	15 (16.9)		
18 to 24 months	52 (6.9)	7 (7.9)		
2 to 5 years	95 (12.6)	12 (13.5)		
5 to 10 years	82 (10.8)	11 (12.4)		
10+ years	43 (5.7)	9 (10.1)		

Table 3: Demographic Information n (%)

	Outpatient Program n=89	Supported Housing Program n=9	Consumer/Survivor Organization n=15	Emergency Shelter n=10	Total N=123
Gender					
Male	33 (37.1)	2 (22.2)	7 (46.7)	8 (80)	50 (40.7)
Female	56 (62.9)	7 (77.8)	8 (53.3)	2 (20)	73 (59.3)
Age					
Mean (SD)	46.4 (12.6)	43.6 (8.5)	46.6 (7.2)	39.9 (14.1)	45.7 (12.0)
Living Arrangements*					
Parents	8 (9)	0 (0)	0	0	8 (6.5)
Spouse	35 (39.3)	0 (0)	4 (26.7)	1 (10)	40 (32.5)
Other relatives	8 (9)	0 (0)	0	0	8 (6.5)
Children	21 (23.6)	1 (11.1)	3 (20)	0	25 (20.3)
Unrelated persons	6 (6.7)	0	0	0	6 (4.9)
Alone	30 (33.7)	8 (88.9)	9 (60)	9 (90)	56 (45.5)
Living Location					
House/Apartment	88 (98.9)	9 (100)	12 (80)	0 (0)	109 (88.6)
Rooming/Boarding House	0 (0)	0 (0)	3 (20)	0 (0)	3 (2.4)
Group Home	1 (1.1)	0 (0)	0 (0)	0 (0)	1 (0.8)
Shelter/Hostel	0 (0)	0 (0)	0 (0)	10 (100)	10 (8.1)
Number of Moves (past year)					
None	72 (80.9)	8 (88.9)	12 (80)	0 (0)	92 (74.8)
1 or More	17 (19.1)	1 (11.1)	3 (20)	10 (100)	31 (25.2)
Current Employment					
Full-time	12 (13.5)	0 (0)	0 (0)	0 (0)	12 (9.8)
Part-time	13 (14.6)	2 (22.2)	5 (33.3)	0 (0)	20 (16.3)
Not Employed	64 (71.9)	7 (77.8)	10 (66.7)	10 (100)	91 (74.0)
Current Volunteer					
Yes	39 (43.8)	5 (55.6)	8 (53.3)	5 (50)	57 (46.3)
No	50 (56.2)	4 (44.4)	7 (46.7)	5 (50)	66 (53.7)
Current Schooling					
Full-time	6 (6.7)	0 (0)	0 (0)	0 (0)	6 (4.9)
Part-time	8 (9.0)	2 (22.2)	3 (13.3)	0 (0)	12 (9.8)
Not in School	75 (84.3)	7 (77.8)	13 (86.7)	10 (100)	105 (85.4)

	Outpatient Program n=89	Supported Housing Program n=9	Consumer/Survivor Organization n=15	Emergency Shelter n=10	Total N=123
Education Status					
Elementary School	6 (6.7)	0 (0)	5 (33.3)	1 (10)	12 (9.8)
Some High School	15 (16.9)	2 (22.2)	5 (33.3)	5 (50)	27 (22.0)
Complete High School	16 (18.0)	0 (0)	1 (6.7)	1 (10)	18 (14.6)
Some Postsecondary	14 (15.7)	4 (44.4)	0 (0)	2 (20)	20 (16.3)
Complete Postsecondary	38 (42.7)	3 (33.3)	4 (26.7)	1 (10)	46 (37.4)
Main Source of Income					
Ontario Works	2 (2.2)	0 (0)	5 (33.3)	4 (40)	11 (8.9)
ODSP	33 (37.1)	4 (44.4)	7 (46.7)	2 (20)	46 (37.4)
CPP Disability Pension	15 (16.9)	3 (33.3)	1 (6.7)	0 (0)	19 (15.4)
CPP Senior Pension	3 (3.4)	1 (11.1)	0 (0)	0 (0)	4 (3.3)
WSIB	1 (1.1)	0 (0)	0 (0)	0 (0)	1 (0.8)
Private Insurance	1 (1.1)	0 (0)	0 (0)	0 (0)	1 (0.8)
Employment Insurance	7 (7.9)	0 (0)	0 (0)	0 (0)	7 (5.7)
Employment Earnings	14 (15.7)	1 (11.1)	1 (6.7)	0 (0)	16 (13.0)
Income from Family	9 (10.1)	0 (0)	1 (6.7)	0 (0)	10 (8.1)
Other	4 (4.5)	0 (0)	0 (0)	4 (40)	8 (6.5)
Cultural/Racial Background					
White	77 (86.5)	7 (77.8)	5 (33.3)	5 (50)	94 (76.4)
Aboriginal	8 (9.0)	0 (0)	9 (60)	3 (30)	20 (16.3)
Métis	0 (0)	2 (22.2)	1 (6.7)	2 (20)	5 (4.1)
Other	3 (3.4)	0 (0)	0 (0)	0 (0)	3 (2.4)
Refused	1 (1.1)	0 (0)	0 (0)	0 (0)	1 (0.8)
Delayed Seeking Mental Health Treatment**					
Yes	45 (50.6)	6 (66.7)	9 (66.3)	5 (50)	65 (53.3)
No	44 (49.4)	3 (33.3)	5 (35.7)	5 (50)	57 (46.7)
If yes, in the past 6 months**					
Yes	4 (9.1)	2 (33.3)	2 (22.2)	2 (40)	10 (15.6)
No	40 (90.9)	4 (66.6)	7 (77.7)	3 (60)	54 (84.4)
Felt Uncomfortable Coming to LPH**					
Yes	43 (48.3)	9 (100)	5 (50)	2 (28.6)	59 (51.3)
No	46 (51.7)	0 (0)	5 (50)	5 (71.4)	56 (48.7)

*Percentages may not equal 100 as more than one response was possible. **Based on complete responses.

Table 4: Stigma Questionnaire n (%)

	1=no stigma	2	3	4	5=most stigma	Mean (SD)
1. I have felt that other will view me unfavourably because I have or had a mental illness.						
Outpatient Program	19 (21.3)	9 (10.1)	30 (33.7)	16 (18)	15 (16.9)	2.99 (1.35)
Supported Housing	0 (0)	1 (11.1)	4 (44.4)	3 (33.3)	1 (11.1)	3.44 (0.88)
Consumer/Survivor	2 (13.3)	4 (26.7)	4 (26.7)	4 (26.7)	1(6.7)	2.87 (1.19)
Emergency Shelter	1 (10)	3 (30)	2 (20)	4 (40)	0 (0)	2.90 (1.10)
Total	22 (17.9)	17 (13.8)	40 (32.5)	27 (22.0)	17 (13.8)	3.00 (1.28)
2. I have been in situations where I have heard other say unfavourable things about people who have or had a mental illness.						
Outpatient Program	13 (14.6)	10 (11.2)	30 (33.7)	17 (19.1)	19 (21.3)	3.21 (1.31)
Supported Housing	0 (0)	1 (11.1)	3 (33.3)	2 (22.2)	3 (33.3)	3.78 (1.09)
Consumer/Survivor	0 (0)	1 (6.7)	7 (46.7)	5 (33.3)	2 (13.3)	3.53 (0.83)
Emergency Shelter	0 (0)	0 (0)	4 (40)	4 (40)	2 (20)	3.80 (0.80)
Total	13 (10.6)	12 (9.8)	44 (35.8)	28 (22.8)	26 (21.1)	3.34 (1.22)
3. I have seen or read things in the mass media about people who have or had a mental illness that I find hurtful or offensive.						
Outpatient Program	16 (18)	24 (27)	23 (25.8)	17 (19.1)	9 (10.1)	2.76 (1.24)
Supported Housing	1 (11.1)	2 (22.2)	2 (22.2)	3 (33.3)	1 (11.1)	3.11 (1.27)
Consumer/Survivor	1 (7.7)	3 (23.1)	4 (30.8)	3 (23.1)	2 (15.4)	3.15 (1.21)
Emergency Shelter	1 (10)	3 (30)	1 (10)	2 (20)	2 (20)	3.20 (1.40)
Total	19 (15.7)	32 (26.4)	30 (24.8)	25 (20.7)	14 (11.6)	2.87 (1.25)
4. I have avoided telling other outside my immediate family that I have or had a mental illness.						
Outpatient Program	13 (14.6)	6 (6.7)	20 (22.5)	23 (25.8)	27 (30.3)	3.51 (1.37)
Supported Housing	1 (11.1)	1 (11.1)	2 (22.2)	3 (33.3)	2 (22.2)	3.44 (1.33)
Consumer/Survivor	6 (40)	1 (6.7)	2 (13.3)	5 (33.3)	1 (6.7)	2.60 (1.50)
Emergency Shelter	2 (20)	1 (10)	2 (20)	4 (40)	1 (10)	3.10 (1.37)
Total	22 (17.9)	9 (7.3)	26 (21.1)	35 (28.5)	31 (25.5)	3.36 (1.40)
5. I have been treated as less competent by others when they learn that I have or had a mental illness.						
Outpatient Program	21 (23.6)	15 (16.9)	28 (31.5)	15 (16.9)	10 (11.2)	2.75 (1.30)
Supported Housing	0 (0)	1 (11.1)	5 (55.6)	2 (22.2)	1 (11.1)	3.33 (0.87)
Consumer/Survivor	4 (26.7)	4 (26.7)	4 (26.7)	3 (20)	0 (0)	2.40 (1.12)
Emergency Shelter	2 (20)	2 (20)	3 (30)	3 (30)	0 (0)	2.70 (1.16)
Total	27 (22.0)	22 (17.9)	40 (32.5)	23 (18.7)	11 (8.9)	2.75 (1.25)
6. I have been shunned or avoided when it was revealed that I have or had a mental illness.						
Outpatient Program	42 (47.7)	9 (10.2)	24 (27.3)	8 (9.1)	5 (5.7)	2.15 (1.27)
Supported Housing	1 (12.5)	3 (37.5)	1 (12.5)	2 (25)	1 (12.5)	2.88 (1.36)
Consumer/Survivor	5 (33.3)	5 (33.3)	4 (26.7)	1 (6.7)	0 (0)	2.07 (0.96)
Emergency Shelter	3 (30)	4 (40)	3 (30)	0 (0)	0 (0)	2.00 (0.82)
Total	51 (42.1)	21 (17.4)	32 (26.4)	11 (9.1)	6 (5.0)	2.17 (1.22)
7. I have been advised to lower my expectations in life because I have or had a mental illness.						
Outpatient Program	40 (44.9)	16 (18)	14 (15.7)	11 (12.4)	8 (9)	2.22 (1.37)
Supported Housing	4 (50)	1 (12.5)	1 (12.5)	0 (0)	2 (25)	2.38 (1.77)
Consumer/Survivor	5 (33.3)	3 (20)	5 (33.3)	1 (6.7)	1 (6.7)	2.33 (1.23)
Emergency Shelter	3 (30)	2 (20)	4 (40)	1 (10)	0 (0)	2.30 (1.06)
Total	52 (42.6)	22 (18.0)	24 (19.7)	13 (10.7)	11 (9.0)	2.25 (1.35)

	1=no stigma	2	3	4	5=most stigma	Mean (SD)
R8. I have been treated fairly by other who know that I have or had a mental illness.						
Outpatient Program	25 (28.7)	26 (29.2)	26 (29.9)	9 (10.3)	1 (1.1)	2.25 (1.03)
Supported Housing	1 (11.1)	3 (33.3)	3 (33.3)	2 (22.2)	0 (0)	2.67 (1.00)
Consumer/Survivor	2 (13.3)	4 (26.7)	4 (26.7)	4 (26.7)	1 (6.7)	2.87 (1.19)
Emergency Shelter	1 (10)	2 (20)	4 (40)	3 (30)	0 (0)	2.90 (0.99)
Total	29 (24.0)	35 (28.9)	37 (30.6)	18 (14.9)	2 (1.7)	2.41 (1.06)
R9. Friends who learned that I use or have used mental health services have been supportive and understanding.						
Outpatient Program	27 (30.7)	33 (37.5)	20 (22.7)	4 (4.5)	4 (4.5)	2.15 (1.06)
Supported Housing	1 (11.1)	3 (33.3)	3 (33.3)	1 (11.1)	1 (11.1)	2.78 (1.20)
Consumer/Survivor	2 (13.3)	7 (46.7)	3 (20)	0 (0)	3 (20)	2.67 (1.35)
Emergency Shelter	2 (20)	3 (30)	3 (30)	0 (0)	2 (20)	2.70 (1.42)
Total	32 (26.2)	46 (37.7)	29 (23.8)	5 (4.1)	10 (8.2)	2.30 (1.15)
10. I have shunned or avoided other people because I know that they have or had a mental illness.						
Outpatient Program	62 (69.7)	11 (12.4)	11 (12.4)	3 (3.4)	2 (2.2)	1.56 (0.99)
Supported Housing	6 (66.7)	1 (11.1)	2 (22.2)	0 (0)	0 (0)	1.56 (0.88)
Consumer/Survivor	3 (20)	4 (26.7)	8 (53.3)	0 (0)	0 (0)	2.33 (0.82)
Emergency Shelter	3 (30)	3 (30)	4 (40)	0 (0)	0 (0)	2.10 (0.88)
Total	74 (60.2)	19 (15.4)	25 (20.3)	3 (2.4)	2 (1.6)	1.70 (0.98)
11. I have felt uncomfortable going to places that provide mental health services because I was afraid of what other people might think about me.						
Outpatient Program	36 (40.4)	11 (12.4)	23 (25.8)	14 (15.7)	4 (4.5)	2.31 (1.28)
Supported Housing	0 (0)	3 (33.3)	3 (33.3)	2 (22.2)	0 (0)	2.88 (0.84)
Consumer/Survivor	5 (33.3)	1 (6.7)	4 (26.7)	4 (26.7)	1 (6.7)	2.67 (1.40)
Emergency Shelter	4 (40)	0 (0)	3 (30)	3 (30)	0 (0)	2.50 (1.35)
Total	45 (37.2)	15 (12.4)	33 (27.3)	23 (19.0)	5 (4.1)	2.40 (1.28)
12. I have felt bad about myself because I have or had a mental illness.						
Outpatient Program	13 (14.8)	5 (5.7)	25 (28.4)	19 (21.6)	26 (29.5)	3.45 (1.36)
Supported Housing	1 (11.1)	1 (11.1)	2 (22.2)	1 (11.1)	3 (33.3)	3.50 (1.51)
Consumer/Survivor	1 (6.7)	1 (6.7)	6 (40)	6 (40)	1 (6.7)	3.33 (0.98)
Emergency Shelter	0 (0)	1 (10)	5 (50)	4 (40)	0 (0)	3.30 (0.68)
Total	15 (12.4)	8 (6.6)	38 (31.4)	30 (24.8)	40 (33.1)	3.43 (1.28)
R13. I have found that mental health professionals treat people who have or had a mental illness with dignity and respect.						
Outpatient Program	51 (57.3)	27 (30.3)	10 (11.2)	1 (11.1)	0 (0)	1.56 (0.74)
Supported Housing	1 (11.1)	5 (55.6)	1 (11.1)	2 (22.2)	0 (0)	2.44 (1.01)
Consumer/Survivor	4 (28.6)	3 (21.4)	7 (50)	0 (0)	0 (0)	2.21 (0.89)
Emergency Shelter	3 (33.3)	3 (33.3)	3 (33.3)	0 (0)	0 (0)	2.00 (0.87)
Total	59 (48.8)	38 (31.4)	21 (17.4)	3 (2.5)	0 (0)	1.74 (0.83)
14. I have avoided indicating on written applications that I have or had a mental illness for fear that it would be used against me.						
Outpatient Program	25 (29.1)	5 (5.8)	8 (9.3)	11 (12.8)	37 (41.6)	3.35 (1.73)
Supported Housing	1 (14.3)	3 (42.9)	0 (0)	1 (14.3)	2 (28.6)	3.00 (1.63)
Consumer/Survivor	3 (21.4)	3 (21.4)	2 (14.3)	1 (7.1)	5 (35.7)	3.14 (1.66)
Emergency Shelter	2 (22.2)	2 (22.2)	2 (22.2)	0 (0)	3 (33.3)	3.00 (1.66)
Total	31 (26.7)	13 (11.2)	12 (10.3)	13 (11.2)	47 (40.5)	3.28 (1.69)

	1=no stigma	2	3	4	5=most stigma	Mean (SD)
R15. I have been treated with kindness and sympathy by law enforcement officers when they learned that I have or had a mental illness.						
Outpatient Program	7 (17.5)	5 (12.5)	3 (7.5)	5 (12.5)	20 (50)	3.65 (1.61)
Supported Housing	0 (0)	1 (25)	0 (0)	0 (0)	3 (75)	4.25 (1.50)
Consumer/Survivor	1 (12.5)	0 (0)	3 (37.5)	1 (12.5)	3 (37.5)	3.63 (1.41)
Emergency Shelter	0 (0)	0 (0)	2 (40)	1 (20)	2 (40)	4.00 (1.00)
Total	8 (14.0)	6 (10.5)	8 (14.0)	7 (12.3)	28 (49.1)	3.71 (1.51)
R16. Coworkers or supervisors at work were supportive and accommodating when they learned that I have or had a mental illness.						
Outpatient Program	8 (16.3)	10 (20.4)	11 (22.4)	8 (16.3)	12 (24.5)	3.12 (1.42)
Supported Housing	1 (50)	1 (50)	0 (0)	0 (0)	0 (0)	1.50 (0.71)
Consumer/Survivor	1 (25)	0 (0)	3 (75)	0 (0)	0 (0)	2.50 (1.00)
Emergency Shelter	0 (0)	0 (0)	2 (100)	0 (0)	0 (0)	3.00 (0)
Total	10 (17.5)	11 (19.3)	16 (28.1)	8 (14.0)	12 (21.1)	3.02 (1.38)
17. I have been turned down for a job for which I was qualified when it was revealed that I have or had a mental illness.						
Outpatient Program	30 (61.2)	2 (4.1)	8 (16.3)	5 (10.2)	4 (8.2)	2.00 (1.40)
Supported Housing	2 (66.7)	1 (33.3)	0 (0)	0 (0)	0 (0)	1.33 (0.58)
Consumer/Survivor	2 (50)	1 (25)	1 (25)	0 (0)	0 (0)	1.75 (0.96)
Emergency Shelter	1 (50)	1 (50)	0 (0)	0 (0)	0 (0)	1.50 (0.71)
Total	35 (60.3)	5 (8.6)	9 (15.5)	5 (8.6)	4 (6.9)	1.93 (1.32)
18. I have been excluded from volunteer or social activities on the basis of my mental health history.						
Outpatient Program	67 (79.8)	6 (7.1)	6 (7.1)	4 (4.8)	1 (1.2)	1.40 (0.91)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	0 (0)	0 (0)	1.33 (0.71)
Consumer/Survivor	12 (85.7)	2 (14.3)	0 (0)	0 (0)	0 (0)	1.14 (0.36)
Emergency Shelter	9 (100)	0 (0)	0 (0)	0 (0)	0 (0)	1.00 (0)
Total	95 (81.9)	9 (7.8)	7 (6.0)	4 (3.4)	1 (0.9)	1.34 (0.81)
19. I have had the fact that I have or had a mental illness used against me in legal proceedings (such as child custody or divorce disputes).						
Outpatient Program	45 (76.3)	1 (1.7)	2 (3.4)	5 (8.5)	6 (10.2)	1.75 (1.42)
Supported Housing	4 (80)	0 (0)	0 (0)	0 (0)	1 (20)	1.80 (1.79)
Consumer/Survivor	6 (66.7)	1 (11.1)	0 (0)	2 (22.2)	0 (0)	1.78 (1.30)
Emergency Shelter	4 (66.7)	1 (16.7)	0 (0)	1 (16.7)	0 (0)	1.67 (1.21)
Total	59 (74.7)	3 (3.8)	2 (2.5)	8 (10.3)	7 (9.0)	1.75 (1.39)
20. I have had difficulty renting an apartment or finding a house when my status as someone who has or had a mental illness was revealed.						
Outpatient Program	62 (84.9)	2 (2.7)	4 (5.5)	1 (1.4)	4 (5.5)	1.40 (1.05)
Supported Housing	5 (83.3)	1 (16.7)	0 (0)	0 (0)	0 (0)	1.33 (0.82)
Consumer/Survivor	7 (58.3)	2 (16.7)	1 (8.3)	1 (8.3)	1 (8.3)	1.92 (1.38)
Emergency Shelter	5 (62.5)	2 (25)	0 (0)	1 (12.5)	0 (0)	1.63 (1.06)
Total	79 (79.8)	7 (7.1)	5 (5.1)	3 (3.0)	5 (5.1)	1.47 (1.08)
21. I have been denied educational opportunities (for example, acceptance into schools for educational programs) when it was revealed that I have or had a mental illness.						
Outpatient Program	61 (92.4)	2 (3)	1 (1.5)	0 (0)	2 (3)	1.18 (0.74)
Supported Housing	7 (100)	0 (0)	0 (0)	0 (0)	0 (0)	1.00 (0)
Consumer/Survivor	9 (90)	1 (10)	0 (0)	0 (0)	0 (0)	1.10 (0.32)
Emergency Shelter	7 (100)	0 (0)	0 (0)	0 (0)	0 (0)	1.00 (0)
Total	84 (93.3)	3 (3.3)	1 (1.1)	0 (0)	2 (2.2)	1.14 (0.65)

	1=no stigma	2	3	4	5=most stigma	Mean (SD)
22. I have been denied a passport, driver's license or other kinds of permits when I revealed that I have or had a mental illness.						
Outpatient Program	63 (91.3)	3 (4.3)	1 (1.4)	0 (0)	2 (2.9)	1.19 (0.73)
Supported Housing	8 (100)	0 (0)	0 (0)	0 (0)	0 (0)	1.00 (0)
Consumer/Survivor	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)	1.22 (0.67)
Emergency Shelter	6 (100)	0 (0)	0 (0)	0 (0)	0 (0)	1.00 (0)
Total	85 (92.4)	4 (4.3)	1 (1.1)	0	2 (2.2)	1.16 (0.67)
23. I have had difficulty with places where I get my money (for example, the bank or the government) when they find out that I have or had a mental illness.						
Outpatient Program	74 (88.1)	5 (6)	1 (1.2)	2 (2.4)	2 (2.4)	1.25 (0.81)
Supported Housing	7 (87.5)	1 (12.5)	0 (0)	0 (0)	0 (0)	1.13 (0.35)
Consumer/Survivor	11 (78.6)	2 (14.3)	0 (0)	0 (0)	1 (7.1)	1.43 (1.09)
Emergency Shelter	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)	1.11 (0.33)
Total	100 (87.0)	9 (7.8)	1 (0.8)	2 (1.7)	3 (2.6)	1.25 (0.79)
R24. People in my religious community have been supportive and understanding when they learned that I have or had a mental illness.						
Outpatient Program	13 (22.4)	7 (12.1)	13 922.4)	5 (8.6)	20 (34.5)	3.21 (1.58)
Supported Housing	3 (42.9)	3 (42.9)	1 (14.3)	0 (0)	0 (0)	1.71 (0.76)
Consumer/Survivor	1 (9.1)	4 (36.4)	2 (18.2)	1 (9.1)	3 (27.3)	3.09 (1.45)
Emergency Shelter	1 (12.5)	2 (25)	2 (25)	1 (12.5)	2 (25)	3.13 (1.46)
Total	18 (21.4)	16 (19.0)	18 (21.4)	7 (8.3)	25 (29.8)	3.06 (1.53)

Table 5: Camberwell Assessment of Need (CAN) Data

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
1. Accommodation								
Outpatient Program	83 (93.3)	4 (4.5)	2 (2.2)	0.80 (1.30)	1.00 (1.26)	2.40 (0.55)	3 (50.0)	2 (33.3)
Supported Housing	7 (77.8)	2 (22.2)	0 (0)	0.50 (0.71)	1.50 (2.12)	2.50 (0.71)	2 (100.0)	2 (100.0)
Consumer/Survivor	6 (40.0)	7 (46.7)	2 (13.3)	1.11 (1.36)	0.63 (1.19)	2.44 (1.01)	6 (66.7)	3 (33.3)
Emergency Shelter	4 (40.0)	5 (50.0)	1 (10.0)	1.17 (1.33)	0.83 (1.33)	2.17 (1.17)	5 (83.3)	3 (50.0)
Total	100 (81.3)	18 (14.6)	5 (4.1)	1.00 (1.23)	0.86 (1.25)	2.36 (0.90)	16 (69.6)	10 (43.5)
2. Food								
Outpatient Program	78 (87.6)	10 (11.2)	1 (1.1)	0.82 (0.60)	0.55 (0.69)	1.18 (0.98)	10 (90.9)	5 (45.5)
Supported Housing	5 (55.6)	4 (44.4)	0 (0)	1.25 (0.96)	1.50 (0.58)	1.75 (0.50)	4 (100.0)	2 (50.0)
Consumer/Survivor	5 (33.3)	5 (33.3)	5 (33.3)	0.30 (0.67)	1.00 (0.67)	2.00 (0.67)	7 (70.0)	3 (30.0)
Emergency Shelter	5 (50.0)	2 (20.0)	3 (30.0)	0.60 (0.89)	1.20 (0.45)	1.80 (0.45)	5 (100.0)	2 (40.0)
Total	93 (75.6)	21 (17.1)	9 (7.3)	0.67 (0.76)	0.93 (0.69)	1.63 (0.81)	26 (86.7)	12 (40.0)
3. Looking after the home								
Outpatient Program	69 (77.5)	19 (21.3)	1 (1.1)	1.00 (1.21)	0.05 (0.22)	1.05 (0.94)	9 (45.0)	6 (30.0)
Supported Housing	5 (62.5)	3 (37.5)	0 (0)	0.33 (0.58)	1.33 (0.58)	1.67 (0.58)	3 (100.0)	2 (66.7)
Consumer/Survivor	11 (73.3)	4 (26.7)	0 (0)	1.00 (1.15)	0.50 (1.00)	1.00 (1.15)	2 (50.0)	2 (50.0)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	0.67 (1.15)	0 (0)	0.67 (1.15)	1 (33.3)	1 (33.3)
Total	92 (75.4)	29 (23.8)	1 (.8)	0.90 (1.12)	0.23 (0.57)	1.07 (0.94)	15 (50.0)	11 (36.7)
4. Self-care								
Outpatient Program	76 (85.4)	11 (12.4)	2 (2.2)	0.85 (0.99)	0 (0)	0.54 (0.52)	8 (61.5)	5 (38.5)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	0 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	15 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Emergency Shelter	10 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Total	109 (88.6)	12 (9.8)	2 (1.6)	0.79 (0.97)	0.14 (0.53)	0.64 (0.63)	9 (64.3)	6 (42.9)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
5. Daytime activities								
Outpatient Program	66 (74.2)	17 (19.1)	6 (6.7)	0.78 (0.85)	0.45 (0.67)	1.23 (1.02)	11 (47.8)	9 (39.1)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	1.00 (1.41)	1.50 (0.71)	2.00 (0)	2 (100.0)	1 (50.0)
Consumer/Survivor	10 (66.7)	5 (33.3)	0 (0)	0.40 (0.55)	1.40 (1.14)	1.80 (1.10)	4 (80.0)	2 (40.0)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (100.0)
Total	92 (74.8)	24 (19.5)	7 (5.7)	0.71 (0.82)	0.67 (0.84)	1.33 (1.03)	17 (54.8)	13 (41.9)
6. Physical health								
Outpatient Program	71 (79.8)	14 (15.7)	4 (4.5)	0.56 (0.70)	1.44 (0.86)	1.88 (1.02)	11 (61.1)	9 (50.0)
Supported Housing	7 (77.8)	2 (22.2)	0 (0)	1.50 (2.12)	1.50 (2.12)	1.50 (2.12)	1 (50.0)	1 (50.0)
Consumer/Survivor	11 (73.3)	0 (0)	4 (26.7)	1.00 (1.15)	0.75 (0.96)	2.25 (0.50)	0 (0)	0 (0)
Emergency Shelter	8 (80.0)	0 (0)	2 (20.0)	1.00 (1.41)	1.00 (1.41)	2.00 (0)	0 (0)	0 (0)
Total	97 (78.9)	16 (13.0)	10 (8.1)	0.73 (0.92)	1.31 (0.97)	1.92 (0.97)	12 (46.2)	10 (38.5)
7. Psychotic symptoms								
Outpatient Program	66 (74.2)	19 (21.3)	4 (4.5)	1.04 (0.82)	1.43 (0.66)	1.73 (0.46)	19 (82.6)	19 (82.6)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	1.00 (0)	1.50 (0.71)	2.00 (0)	2 (100.0)	1 (50.0)
Consumer/Survivor	12 (80.0)	3 (20.0)	0 (0)	1.33 (1.53)	1.67 (1.15)	2.33 (0.58)	3 (100.0)	1 (33.3)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	1.00 (0)	1.00 (0)	2.00 (0)	1 (100.0)	0 (0)
Total	94 (76.4)	24 (19.5)	5 (4.1)	1.07 (0.84)	1.45 (0.69)	1.82 (0.48)	25 (86.2)	21 (72.4)
8. Information on condition and treatment								
Outpatient Program	65 (73.0)	22 (24.7)	2 (2.2)	0.83 (.82)	1.04 (0.98)	1.96 (0.86)	13 (54.2)	8 (33.3)
Supported Housing	6 (75.0)	1 (12.5)	1 (12.5)	0.50 (.71)	1.50 (0.71)	2.50 (0.71)	1 (50.0)	0 (0)
Consumer/Survivor	12 (85.7)	1 (7.1)	1 (7.1)	0.50 (.71)	2.50 (0.71)	2.50 (0.71)	2 (100.0)	1 (50.0)
Emergency Shelter	8 (88.9)	0 (0)	1 (11.1)	0 (0)	3.00 (0)	3.00 (0)	1 (100.0)	0 (0)
Total	91 (75.8)	24 (20.0)	5 (4.2)	0.76 (.79)	1.25 (1.04)	2.07 (0.84)	17 (58.6)	9 (31.0)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
9. Psychological distress								
Outpatient Program	26 (29.2)	44 (49.4)	19 (21.3)	1.42 (0.88)	1.41 (0.74)	1.73 (0.63)	50 (79.4)	42 (66.7)
Supported Housing	3 (33.3)	4 (44.4)	2 (22.2)	1.33 (1.03)	1.50 (0.84)	1.83 (0.98)	6 (100.0)	4 (66.7)
Consumer/Survivor	7 (46.7)	7 (46.7)	1 (6.7)	0.75 (0.89)	1.50 (0.93)	2.00 (0.53)	7 (87.5)	4 (50.0)
Emergency Shelter	6 (60.0)	4 (40.0)	0 (0)	1.00 (0.82)	1.50 (0.58)	2.00 (0)	4 (100.0)	2 (50.0)
Total	42 (34.1)	59 (48.0)	22 (17.9)	1.33 (0.90)	1.43 (0.75)	1.78 (0.64)	67 (82.7)	52 (64.2)
10. Safety to self								
Outpatient Program	61 (69.3)	16 (18.2)	11 (12.5)	1.15 (1.17)	1.26 (0.86)	1.74 (0.76)	20 (74.1)	17 (63.0)
Supported Housing	6 (66.7)	2 (22.2)	1 (11.1)	1.00 (1.00)	1.33 (0.58)	1.67 (0.58)	3 (100.0)	2 (66.7)
Consumer/Survivor	13 (86.7)	2 (13.3)	0 (0)	1.00 (0)	2.00 (1.41)	2.50 (0.71)	2 (100.0)	1 (50.0)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	1.00 (0)	1.00 (0)	2.00 (0)	1 (100.0)	0 (0)
Total	89 (73.0)	21 (17.2)	12 (9.8)	1.12 (1.08)	1.30 (0.85)	1.79 (0.74)	26 (78.8)	20 (60.6)
11. Safety to others								
Outpatient Program	86 (97.7)	2 (2.3)	0 (0)	1.00 (1.41)	1.50 (0.71)	1.50 (0.71)	2 (100.0)	2 (100.0)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	2.00 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	14 (93.3)	1 (6.7)	0 (0)	0 (0)	0 (0)	1.00 (0)	0 (0)	0 (0)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	0 (0)	0 (0)	1.00 (0)	0 (0)	0 (0)
Total	117 (95.9)	5 (4.1)	0 (0)	0.80 (1.10)	1.00 (1.00)	1.40 (0.55)	3 (60.0)	3 (60.0)
12. Alcohol								
Outpatient Program	83 (94.3)	4 (4.5)	1 (1.1)	1.00 (1.00)	1.80 (0.45)	1.80 (0.45)	5 (100.0)	4 (80.0)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	2.00 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	11 (73.3)	1 (6.7)	3 (20.0)	0.75 (0.96)	0.75 (0.96)	1.75 (1.26)	3 (75.0)	3 (75.0)
Emergency Shelter	7 (70.0)	0 (0)	3 (30.0)	0.67 (1.15)	0.67 (1.15)	1.67 (1.53)	2 (66.7)	3 (100.0)
Total	109 (89.3)	6 (4.9)	7 (5.7)	0.92 (0.95)	1.23 (0.93)	1.77 (0.93)	11 (84.6)	11 (84.6)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
13. Drugs								
Outpatient Program	84 (96.6)	1 (1.1)	2 (2.3)	0.33 (0.58)	1.33 (1.53)	1.67 (1.15)	2 (66.7)	2 (66.7)
Supported Housing	6 (66.7)	2 (22.2)	1 (11.1)	1.00 (1.00)	1.33 (1.15)	1.33 (1.15)	2 (66.7)	2 (66.7)
Consumer/Survivor	14 (93.3)	0 (0)	1 (6.7)	1.00 (0)	1.00 (0)	3.00 (0)	1 (100.0)	0 (0)
Emergency Shelter	9 (90.0)	0 (0)	1 (10.0)	1.00 (0)	1.00 (0)	3.00 (0)	1 (100.0)	0 (0)
Total	113 (93.4)	3 (2.5)	5 (4.1)	0.75 (0.71)	1.25 (1.04)	1.88 (1.13)	6 (75.0)	4 (50.0)
14. Company								
Outpatient Program	44 (50.0)	26 (29.5)	18 (20.5)	1.11 (0.92)	0.55 (0.82)	1.46 (0.91)	21 (47.7)	13 (29.5)
Supported Housing	5 (55.6)	3 (33.3)	1 (11.1)	0.75 (0.96)	1.75 (0.50)	2.00 (0)	3 (75.0)	3 (75.0)
Consumer/Survivor	10 (66.7)	4 (26.7)	1 (6.7)	0.80 (0.84)	0.80 (0.45)	2.00 (0)	3 (60.0)	1 (20.0)
Emergency Shelter	8 (80.0)	1 (10.0)	1 (10.0)	1.50 (0.71)	1.00 (0)	2.00 (0)	2 (100.0)	0 (0)
Total	67 (54.9)	34 (27.9)	21 (17.2)	1.07 (0.90)	0.67 (0.82)	1.56 (0.85)	29 (52.7)	17 (30.9)
15. Intimate relationships								
Outpatient Program	58 (66.7)	15 (17.2)	14 (16.1)	0.62 (0.86)	0.48 (0.74)	2.04 (1.02)	11 (37.9)	9 (31.0)
Supported Housing	7 (87.5)	0 (0)	1 (12.5)	0 (.00)	1.00 (.00)	0 (0)	1 (100.0)	0 (0)
Consumer/Survivor	11 (73.3)	4 (26.7)	0 (0)	1.00 (0.82)	1.25 (0.96)	2.00 (0)	3 (75.0)	2 (50.0)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	1.00 (1.00)	1.33 (1.15)	2.00 (0)	3 (100.0)	2 (66.7)
Total	83 (69.2)	22 (18.3)	15 (12.5)	0.68 (0.85)	0.65 (0.82)	2.03 (0.92)	18 (48.6)	13 (35.1)
16. Sexual expression								
Outpatient Program	56 (65.9)	12 (14.1)	17 (20.0)	0.17 (0.38)	0.31 (0.60)	1.74 (1.05)	6 (20.7)	8 (27.6)
Supported Housing	5 (83.3)	1 (16.7)	0 (0)	0 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	15 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Emergency Shelter	10 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Total	86 (74.1)	13 (11.2)	17 (14.7)	0.17 (0.38)	0.37 (0.67)	1.75 (1.03)	7 (23.3)	9 (30.0)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
17. Child care								
Outpatient Program	81 (93.1)	5 (5.7)	1 (1.1)	0.83 (0.98)	1.00 (1.26)	1.50 (1.22)	3 (50.0)	3 (50.0)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	2.00 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	14 (93.3)	1 (6.7)	0 (0)	2.00 (0)	0 (0)	0 (0)	1 (100.0)	1 (100.0)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	2.00 (0)	0 (0)	0 (0)	1 (100.0)	1 (100.0)
Total	112 (92.6)	8 (6.6)	1 (.8)	1.22 (0.97)	0.89 (1.17)	1.22 (1.20)	6 (66.7)	6 (66.7)
18. Basic education								
Outpatient Program	83 (94.3)	5 (5.7)	0 (0)	1.00 (0.71)	1.20 (1.10)	1.60 (1.14)	4 (80.0)	3 (60.0)
Supported Housing	7 (77.8)	2 (22.2)	0 (0)	0.50 (0.71)	1.50 (0.71)	1.50 (0.71)	2 (100.0)	2 (100.0)
Consumer/Survivor	9 (60.0)	6 (40.0)	0 (0)	0.50 (0.55)	0.83 (0.75)	1.50 (0.84)	6 (100.0)	3 (50.0)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	0.67 (0.58)	1.33 (0.58)	1.67 (0.58)	3 (100.0)	2 (66.7)
Total	106 (86.9)	16 (13.1)	0 (0)	0.69 (0.60)	1.13 (0.81)	1.56 (0.81)	15 (93.8)	10 (62.5)
19. Telephone								
Outpatient Program	87 (98.9)	0 (0)	1 (1.1)	0 (0)	0 (0)	3.00 (0)	0 (0)	0 (0)
Supported Housing	8 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Consumer/Survivor	9 (60.0)	2 (13.3)	4 (26.7)	1.17 (0.98)	1.00 (0.63)	2.50 (0.55)	5 (83.3)	1 (16.7)
Emergency Shelter	6 (60.0)	2 (20.0)	2 (20.0)	1.25 (0.96)	0.75 (0.50)	2.75 (0.50)	4 (100.0)	0 (.0)
Total	110 (90.9)	4 (3.3)	7 (5.8)	1.09 (0.94)	0.82 (0.60)	2.64 (0.50)	9 (81.8)	1 (9.1)
20. Transport								
Outpatient Program	75 (86.2)	8 (9.2)	4 (4.6)	1.25 (1.29)	1.25 (0.97)	1.83 (0.72)	9 (75.0)	5 (41.7)
Supported Housing	9 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Consumer/Survivor	7 (46.7)	7 (46.7)	1 (6.7)	0.75 (0.71)	0.75 (0.71)	1.63 (0.52)	7 (87.5)	1 (12.5)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	.67 (.58)	0.33 (0.58)	1.33 (0.58)	2 (66.7)	0 (.0)
Total	98 (81.0)	18 (14.9)	5 (4.1)	1.00 (1.04)	0.96 (0.88)	1.70 (0.63)	18 (78.3)	6 (26.1)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
21. Money								
Outpatient Program	58 (65.9)	16 (18.2)	14 (15.9)	0.53 (0.82)	0.57 (0.73)	1.10 (0.82)	17 (56.7)	16 (53.3)
Supported Housing	3 (33.3)	6 (66.7)	0 (0)	0.33 (0.52)	1.50 (0.55)	1.50 (0.55)	6 (100.0)	5 (83.3)
Consumer/Survivor	8 (53.3)	4 (26.7)	3 (20.0)	0.14 (0.38)	0.43 (0.79)	0.71 (0.95)	4 (57.1)	5 (71.4)
Emergency Shelter	7 (70.0)	2 (20.0)	1 (10.0)	0.33 (0.58)	1.00 (1.00)	1.00 (1.00)	3 (100.0)	3 (100.0)
Total	76 (62.3)	28 (23.0)	18 (14.8)	0.43 (0.72)	0.70 (0.79)	1.09 (0.82)	30 (65.2)	29 (63.0)
22. Benefits								
Outpatient Program	68 (81.0)	6 (7.1)	10 (11.9)	0.38 (0.72)	0.63 (0.72)	1.94 (1.18)	5 (31.3)	5 (31.3)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	0 (0)	1.00 (1.41)	2.00 (1.41)	1 (50.0)	0 (0)
Consumer/Survivor	11 (78.6)	1 (7.1)	2 (14.3)	0.67 (1.15)	1.00 (1.00)	2.33 (0.58)	2 (66.7)	1 (33.3)
Emergency Shelter	8 (80.0)	0 (0)	2 (20.0)	0 (0)	0.50 (0.71)	2.50 (0.71)	1 (50.0)	0 (0)
Total	94 (80.3)	8 (6.8)	15 (12.8)	0.35 0(.71)	0.70 (0.76)	2.04 (1.07)	9 (39.1)	6 (26.1)
23. Leisure time								
Outpatient Program	67 (76.1)	13 (14.8)	8 (9.1)	0.76 (0.83)	0.38 (0.74)	1.26 (0.87)	9 (42.9)	6 (28.6)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	1.00 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Consumer/Survivor	9 (60.0)	6 (40.0)	0 (0)	0.33 (0.52)	1.50 (0.84)	2.33 (0.52)	5 (83.3)	2 (33.3)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	0.33 (0.58)	1.00 (0)	2.00 (0)	3 (100.0)	0 (0)
Total	91 (74.6)	23 (18.9)	8 (6.6)	0.65 (0.75)	0.71 (0.86)	1.59 (0.87)	18 (58.1)	9 (29.0)
24. Smoking cessation								
Outpatient Program	59 (67.0)	23 (26.1)	6 (6.8)	1.07 (1.03)	0.62 (0.90)	1.41 (1.12)	13 (44.8)	14 (48.3)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	2.00 (1.41)	0.50 (0.71)	1.50 (2.12)	2 (100.0)	1 (50.0)
Consumer/Survivor	12 (80.0)	3 (20.0)	0 (0)	0.67 (1.15)	0 (0)	1.33 (1.15)	2 (66.7)	1 (33.3)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	0.67 (1.15)	0 (0)	1.33 (1.15)	2 (66.7)	1 (33.3)
Total	85 (69.7)	30 (24.6)	7 (5.7)	1.05 (1.05)	0.51 (0.84)	1.40 (1.12)	19 (51.4)	17 (45.9)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
25. Employment								
Outpatient Program	68 (80.0)	6 (7.1)	11 (12.9)	0.53 (0.80)	0.65 (0.93)	1.88 (1.05)	9 (52.9)	6 (35.3)
Supported Housing	7 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Consumer/Survivor	13 (86.7)	0 (0)	2 (13.3)	0 (0)	1.50 (0.71)	2.00 (0)	1 (50.0)	1 (50.0)
Emergency Shelter	9 (90.0)	0 (0)	1 (10.0)	0 (0)	2.00 (0)	2.00 (0)	1 (100.0)	1 (100.0)
Total	97 (82.9)	6 (5.1)	14 (12.0)	0.45 (0.76)	0.80 (0.95)	1.90 (0.97)	11 (55.0)	8 (40.0)
26. Crisis services								
Outpatient Program	78 (89.7)	6 (6.9)	3 (3.4)	0.44 (0.73)	0.44 0(.73)	2.11 (0.33)	2 (22.2)	1 (11.1)
Supported Housing	7 (87.5)	1 (12.5)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Consumer/Survivor	14 (93.3)	1 (6.7)	0 (0)	1.00 (0)	1.00 (0)	2.00 (0)	1 (100.0)	0 (0)
Emergency Shelter	9 (90.0)	1 (10.0)	0 (0)	1.00 (0)	1.00 (0)	2.00 (0)	1 (100.0)	0 (0)
Total	108 (90.0)	9 (7.5)	3 (2.5)	0.50 (0.67)	0.50 (0.67)	2.09 (0.30)	4 (33.3)	1 (8.3)
27. Family doctor								
Outpatient Program	77 (88.5)	9 (10.3)	1 (1.1)	0.50 (0.71)	0.90 (0.57)	1.40 (0.84)	4 (40.0)	4 (40.0)
Supported Housing	7 (77.8)	1 (11.1)	1 (11.1)	0 (0)	1.50 (2.12)	3.00 (0)	1 (50.0)	0 (0)
Consumer/Survivor	11 (73.3)	2 (13.3)	2 (13.3)	0.25 (0.50)	0.25 (0.50)	3.00 (0)	2 (50.0)	0 (0)
Emergency Shelter	8 (80.0)	1 (10.0)	1 (10.0)	0.50 (0.71)	.0 (0)	3.00 (0)	1 (50.0)	0 (0)
Total	103 (85.1)	13 (10.7)	5 (4.1)	0.39 (0.61)	0.72 (0.83)	2.11 (1.02)	8 (44.4)	4 (22.2)
28. Planning for the future								
Outpatient Program	54 (63.5)	26 (30.6)	5 (5.9)	0.77 (0.80)	0.74 0(.77)	1.67 (0.80)	14 (45.2)	13 (41.9)
Supported Housing	6 (66.7)	3 (33.3)	0 (0)	0.67 (0.58)	2.00 (0)	2.00 (0)	3 (100.0)	3 (100.0)
Consumer/Survivor	10 (66.7)	4 (26.7)	1 (6.7)	1.00 (0.71)	1.60 (0.89)	2.40 (0.55)	5 (100.0)	2 (40.0)
Emergency Shelter	7 (70.0)	3 (30.0)	0 (0)	1.33 (0.58)	1.33 (0.58)	2.00 (0)	3 (100.0)	1 (33.3)
Total	77 (64.7)	36 (30.3)	6 (5.0)	0.83 (0.76)	0.98 (0.84)	1.80 (0.75)	25 (59.5)	19 (45.2)

	Presence of a need?			Answered if a need (met or unmet) is present (1 or 2)				
	No Need n (%)	Met Need n (%)	Unmet Need n (%)	Friends/ Relatives -help received Mean (SD)	Local Services - help received Mean (SD)	Local Services - help needed Mean (SD)	Getting right type of help n (%)	Satisfied with amount of help n (%)
	0	1	2	0=No help 1=Low Help 2=Moderate help 3=High help			Yes	Yes
29. Self-help/Peer support								
Outpatient Program	72 (83.7)	9 (10.5)	5 (5.8)	0.43 (0.76)	0.79 (0.80)	2.00 (0.71)	6 (42.9)	4 (28.6)
Supported Housing	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)	2.00 (0)	0 (0)	0 (0)
Consumer/Survivor	15 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Emergency Shelter	10 (100.0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Total	105 (87.5)	10 (8.3)	5 (4.2)	0.40 (0.74)	0.73 (0.80)	2.00 (0.68)	6 (40.0)	4 (26.7)

Table 6: Comparison of responses to stigma questionnaire by delayed seeking mental health services

	Delayed?	N	Mean (SD)	t	p
1. Others viewed unfavourably	No	57	2.54 (1.28)	-3.81	<.001
	Yes	65	3.38 (1.16)		
2. Heard unfavourable things	No	57	3.04 (1.34)	-2.68	.01
	Yes	65	3.62 (1.06)		
3. Heard offensive media	No	57	2.51 (1.15)	-3.26	.01
	Yes	63	3.22 (1.24)		
4. Avoid telling others	No	57	3.12 (1.48)	-1.76	.08
	Yes	65	3.57 (1.32)		
5. Treated less competent	No	57	2.53 (1.27)	-1.77	.08
	Yes	65	2.92 (1.20)		
6. Shunned or avoided by others	No	56	1.75 (1.12)	-3.76	<.001
	Yes	64	2.55 (1.19)		
7. Told to lower expectations	No	56	1.86 (1.12)	-3.18	.002
	Yes	65	2.60 (1.45)		
R8. Treated fairly by others	No	56	2.27 (1.09)	-1.36	0.18
	Yes	64	2.53 (1.04)		
R9: Friends supportive and understanding	No	56	2.20 (1.13)	-0.97	0.34
	Yes	65	2.40 (1.17)		
10. Shunned or avoided others	No	57	1.51 (0.83)	-2.03	.05
	Yes	65	1.86 (1.09)		
11. Uncomfortable going to mental health places	No	56	2.00 (1.18)	-3.51	.001
	Yes	64	2.78 (1.25)		
12. Felt bad about self	No	55	2.98 (1.28)	-3.74	<.001
	Yes	65	3.82 (1.16)		
R13. Mental health professionals respectful	No	55	1.71 (0.83)	-0.29	0.77
	Yes	65	1.75 (0.85)		
14. Written applications	No	53	2.98 (1.73)	-1.74	.09
	Yes	63	3.52 (1.64)		
R15. Kindness/sympathy from law enforcement	No	26	3.65 (1.60)	-0.27	0.79
	Yes	30	3.77 (1.48)		
R16. Coworkers supportive and accommodating	No	26	2.92 (1.35)	-0.47	0.64
	Yes	31	3.10 (1.42)		
17. Turned down for job	No	24	1.67 (1.09)	-1.35	0.20
	Yes	34	2.12 (1.45)		
18. Excluded from volunteering/social activities	No	52	1.27 (0.72)	-0.83	0.41
	Yes	63	1.40 (0.89)		
19. Legal proceedings	No	40	1.45 (1.15)	-1.94	0.06
	Yes	39	2.05 (1.56)		
20. Difficulty renting or finding housing	No	48	1.31 (0.88)	-1.51	0.13
	Yes	50	1.64 (1.24)		
21. Denied educational opportunities	No	44	1.09 (0.36)	-0.77	0.45
	Yes	46	1.20 (0.83)		

	Delayed?	N	Mean (SD)	t	p
22. Denied permits	No	44	1.07 (0.33)	-1.35	0.18
	Yes	48	1.25 (0.86)		
23. Difficulty at places where get money	No	54	1.19 (0.55)	-0.88	0.38
	Yes	60	1.32 (0.97)		
R24. Religious community supportive	No	39	3.33 (1.47)	1.53	0.13
	Yes	44	2.82 (1.57)		
Total	No	52	51.0 (13.5)	-3.61	<.001
	Yes	60	60.3 (13.7)		

Table 7: Comparison of mean (SD) presence of need (need and unmet need) on the Camberwell Assessment of Need (CAN) by delayed seeking mental health services

Delayed?	N	Mean (SD)	t	p
Yes	65	7.23 (4.31)	-2.48	.02
No	56	5.36 (3.98)		

Table 8: Comparison of presence of need (need and unmet need) on the Camberwell Assessment of Need (CAN) by delayed seeking mental health services

	Yes, delayed n (%)		No delay n (%)		χ^2	p
	Need	No Need	Need	No Need		
1. Accommodation	11 (16.9)	54 (83.1)	11 (19.3)	46 (80.7)	0.12	0.73
2. Food	17 (26.2)	48 (73.8)	12 (21.1)	45 (78.9)	0.44	0.51
3. Looking after the home	19 (29.7)	45 (70.3)	10 (17.5)	47 (82.5)	2.44	0.12
4. Self-care	10 (15.4)	55 (84.6)	4 (7)	43 (93)	2.03	0.15
5. Daytime activities	20 (30.8)	45 (69.2)	11 (19.3)	46 (80.7)	2.11	0.15
6. Physical health	14 (21.5)	51 (78.5)	11 (19.3)	46 (80.7)	.09	0.76
7. Psychotic symptoms	16 (24.6)	49 (75.4)	13 (22.8)	44 (77.2)	.06	0.82
8. Information	16 (24.6)	49 (75.4)	12 (22.2)	42 (77.8)	.09	0.76
9. Psychological distress	49 (75.4)	16 (24.6)	31 (54.4)	26 (45.6)	5.93	.02
10. Safety to self	26 (40)	39 (60)	7 (12.5)	49 (87.5)	11.47	.01
11. Safety to others	5 (7.7)	60 (92.3)	0 (0)	56 (100)	4.49	.03
12. Alcohol	5 (7.7)	60 (92.3)	8 (14.3)	48 (85.7)	1.36	0.24
13. Drugs	5 (7.8)	59 (92.2)	2 (3.6)	54 (96.4)	0.98	0.32
14. Company	31 (47.7)	34 (52.3)	23 (41.1)	33 (58.9)	0.53	0.47
15. Intimate relationships	25 (38.5)	40 (61.5)	12 (22.2)	42 (77.8)	3.63	.07
16. Sexual expression	19 (30.6)	43 (69.4)	11 (20.8)	42 (79.2)	1.45	0.23
17. Child care	3 (4.7)	61 (95.3)	5 (8.9)	51 (91.1)	0.86	0.35
18. Basic education	9 (13.8)	56 (86.2)	6 (10.7)	50 (89.3)	0.27	0.60
19. Telephone	6 (9.2)	59 (90.8)	4 (7.3)	51 (92.7)	0.15	0.70
20. Transport	11 (17.2)	53 (82.8)	12 (21.4)	44 (78.6)	0.35	0.56
21. Money	29 (44.6)	36 (55.4)	16 (28.6)	40 (71.4)	3.32	.07
22. Benefits	13 (21)	49 (79)	10 (18.5)	44 (81.5)	0.11	0.74
23. Leisure time	18 (27.7)	47 (73.3)	12 (21.4)	(78.6)	0.63	0.43
24. Smoking cessation	23 (35.4)	42 (64.6)	14 (25)	42 (75)	1.53	0.22
25. Employment	9 (14.5)	53 (85.5)	11 (20.4)	43 (79.6)	0.69	0.41
26. Crisis Services	8 (12.5)	56 (87.5)	4 (7.3)	51 (92.7)	0.89	0.35
27. Family doctor	11 (17.2)	53 (82.8)	7 (12.5)	49 (87.5)	0.52	0.47
28. Planning for the future	29 (46)	34 (54)	13 (23.6)	42 (76.4)	6.42	.01
29. Self-help/Peer support	9 (14.1)	55 (85.9)	6 (10.9)	49 (89.1)	0.27	0.61

Table 9: Comparison of mean (SD) of unmet need on the Camberwell Assessment of Need (CAN) by delayed seeking mental health services

Delayed?	N	Mean (SD)	t	p
Yes	65	2.32 (2.58)	-1.88	.06
No	56	1.49 (2.24)		

Table 10: Comparison of unmet need on the Camberwell Assessment of Need (CAN) by delayed seeking mental health services

	Yes, delayed n (%)		No delay n (%)		χ^2	p
	No/met Need	Unmet Need	No/met Need	Unmet Need		
1. Accommodation	62 (95.4)	3 (4.6)	55 (96.5)	2 (3.5)	0.10	0.76
2. Food	61 (9.38)	4 (6.2)	52 (91.2)	5 (8.8)	0.31	0.58
3. Looking after the home	64 (100)	0 (0)	56 (98.2)	1 (1.8)	1.13	0.29
4. Self-care	63 (96.9)	2 (3.1)	57 (100)	0 (0)	1.78	0.18
5. Daytime activities	59 (90.8)	6 (9.2)	57 (98.2)	1 (1.8)	3.14	.08
6. Physical health	60 (93.2)	5 (7.7)	53 (93)	4 (7)	.02	0.89
7. Psychotic symptoms	62 (95.4)	3 (4.6)	55 (96.5)	2 (3.5)	.09	0.76
8. Information	62 (95.4)	3 (4.6)	53 (98.1)	1 (1.9)	0.69	0.41
9. Psychological distress	49 (75.4)	16 (24.6)	51 (89.5)	6 (10.5)	4.08	.04
10. Safety to self	55 (84.6)	10 (15.4)	54 (96.4)	2 (3.6)	4.70	.03
11. Safety to others	65 (100)	0 (0)	56 (100)	0 (0)	n/a	n/a
12. Alcohol	64 (98.5)	1 (1.5)	50 (89.3)	6 (10.7)	4.65	.03
13. Drugs	62 (96.9)	2 (3.1)	54 (96.4)	2 (3.6)	.02	0.89
14. Company	54 (83.1)	11 (16.9)	47 (83.9)	9 (16.1)	.02	0.90
15. Intimate relationships	53 (81.5)	12 (18.5)	51 (94.4)	3 (5.6)	4.46	.04
16. Sexual expression	51 (82.3)	11 (17.7)	47 (88.7)	6 (11.3)	0.94	0.33
17. Child care	63 (98.4)	1 (1.6)	56 (100)	0(0)	0.88	0.35
18. Basic education	65 (100)	0 (0)	56 (100)	0 (0)	n/a	n/a
19. Telephone	62 (95.4)	3 (4.6)	52 (94.5)	3 (5.5)	.04	0.83
20. Transport	62 (96.9)	2 (3.1)	53 (94.6)	3 (5.4)	0.37	0.54
21. Money	53 (81.5)	12 (18.5)	50 (89.3)	6 (10.7)	1.43	0.23
22. Benefits	53 (85.5)	9 (14.5)	48 (88.9)	6 (11.1)	0.30	0.59
23. Leisure time	60 (92.3)	5 (7.7)	53 (94.6)	3 (5.4)	0.27	0.61
24. Smoking cessation	61 (93.8)	4 (6.2)	53 (94.6)	3 (5.4)	.04	0.85
25. Employment	53 (85.5)	9 (14.5)	49 (90.7)	5 (9.3)	0.75	0.39
26. Crisis Services	62 (96.9)	2 (3.1)	54 (98.2)	1 (1.8)	0.21	0.65
27. Family doctor	60 (93.8)	4 (6.3)	55 (98.2)	1 (1.8)	1.49	0.22
28. Planning for the future	58 (92.1)	5 (7.9)	54 (98.2)	1 (1.8)	2.28	0.13
29. Self-help/Peer support	60 (93.8)	4 (6.3)	54 (98.2)	1 (1.8)	1.44	0.23

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